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ABSTRACT

The study reported here describes the development and testing of a curriculum model to extend the role of public health nurses into community nurse practitioners (CNP). The content is presented in six chapters. The first chapter overviews the conceptual framework for the CNP role and then describes the three-course sequence comprising the CNP track of the master's program at the University of Texas School of Public Health. After briefly describing the program graduates, the next chapter presents the master's projects written by graduates, staff perceptions of the graduates as students, and the results of a program evaluation survey of graduates. Chapter 3 on community outcome analysis covers health needs and community change. The next chapter, which is the development of a community-oriented health record (recordkeeping system), discusses the development of forms (includes form samples) to facilitate community intervention and evaluation. The results of a preliminary study concerning the effect of a nine-month learning experience on students' attitudes toward working in the community and with community groups are reported in chapter 5. The last chapter summarizes the opinions of a panel of experts who reviewed the CNP program. Course descriptions for CNP seminars and the graduate evaluation questionnaire are appended. (EM)

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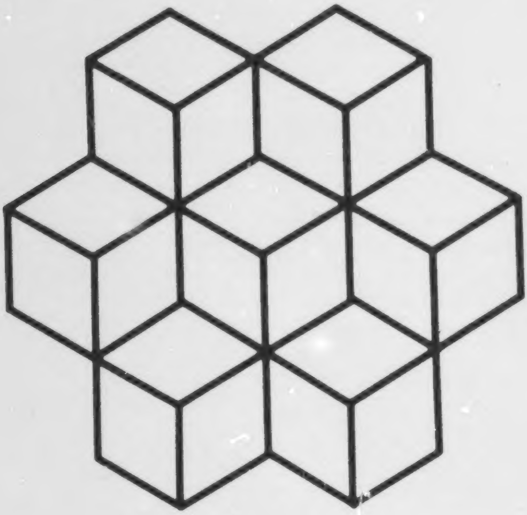
THE DEVELOPMENT AND IMPLEMENTATION OF A CURRICULUM MODEL FOR COMMUNITY NURSE PRACTITIONERS



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August 1977

Health Manpower References

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FOREWORD

Educators of nursing in community and public health, and administrators of nursing and health services are universally concerned with the need to change curriculum preparing public health professionals and to alter patterns of utilization of nursing staff for more effective functioning. In spite of this recognized need for change, there are few resource materials and little information available to provide guidance for planning and directing curriculum revision. This report resulted from the Division's concern to help meet the expressed needs of those involved in the changing patterns of public health education and practice.

Beginning in 1971 and continuing for 5 years, the University of Texas School of Public Health, under contract with the Division of Nursing, undertook a study to develop and test a curriculum model for extending the role of the public health nurse. The model and the recommendations growing out of the study are presented in this publication. It will prove a solid reference and useful guide in the interest of public health education, service, and research.

Jessie M. Scott

Jessie M. Scott
Assistant Surgeon General
Director
Division of Nursing

PREFACE

In a contract awarded June 26, 1971, the Division of Nursing asked the University of Texas School of Public Health (UTSPH) to develop a role model appropriate for the nurse working in today's communities. Awarded on a yearly basis, the contract has continued for 5 years. The first year was spent in developing a conceptual framework for the role, thereafter four to six students were accepted annually into the academic program, with one or two students usually remaining for portions of a second year. An article describing the Community Nurse Practitioner (CNP) role, should be read by anyone who is not yet familiar with the CNP concept.[1]

Taking advantage of the considerable freedom afforded by the Division of Nursing and the School of Public Health, numerous revisions were made in the program relating to the development of this role model. We approached our task in the same manner in which we encouraged our students to approach community problems—with a willingness to listen, to learn, and to work with all the people concerned. As a result, the program had continual input not only from the Division of Nursing and the UTSPH project staff, but also from students and community residents.

This input, of course, did not arrive simultaneously, nor did opinions and attitudes remain consistent, thus giving the program an evolutionary perspective over time. Allowing the role to "emerge" in this manner occasionally proved very frustrating to all concerned, but, we believe, it also permitted the development of a product far superior to any that might have been developed had the process been frozen at some point along the way.

It is in this same spirit that we wish to share our report now. Described in this report are some glimpses into an ongoing process involving the responses of students, faculty, and community residents to some of today's health needs. Only in the continuation of this evolutionary process—by other students, faculty, and residents—will this role authentically respond to the needs of tomorrow.

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[1] Skrovan, Clarence; Anderson, Elizabeth T.; Gottschalk, Janet. "The Community Nurse Practitioner: An Emerging Role," *American Journal of Public Health*, Sept. 1974, pp. 847–853.

In our attempts at response, we have grappled with some complex and perplexing issues. Is this nursing? What is nursing? How is the health of a community measured? What is health? Who is responsible for a community's health? Aren't professionals supposed to have all the answers? Is it safe to do this? What does the Third World have to do with Houston, Texas?

All in all, it has been fun. What follows is an attempt to document some of what we did. We do not leave a finished product. What we leave is the beginning of a new role—handing it on to others to continue its development.

If we were to name all those to whom we are indebted, we would have to double the size of this final report.

There are some very special people, however, without whom the Community Nurse Practitioner Project would never have been:

envisioned -------------- Doris E. Roberts;
launched --------------- Bobbe Christensen and Fongee Jeu;
supported -------------- Division of Nursing and University of Texas School of Public Health; and
brought to fruition ------ the students.

The Authors

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Chapter 1

COMMUNITY NURSE PRACTITIONER CURRICULUM

Overview

Presented here is a brief introduction to the development of a conceptual framework for the CNP role, an overview of the role within the framework of the nursing process, and a description of the three-course sequence which makes up the community nurse practitioner track of the Master's of Public Health program.

The conceptual framework was developed through an interactive approach. It was comprised of three dimensions or components: the students, the setting, and the subject. The students were registered nurses pursuing graduate education at the University of Texas School of Public Health (UTSPH) and well motivated toward broadening their education. Their goals were to improve health and look at health care with a broad community focus. The staffs' approach to these students was based on a belief in freedom and self-directedness for the students, with expectations of their full-time involvement in the program. (Part-time students were not accepted into the program.)

The setting for development of this program was the UTSPH. It is a school that has no department of nursing and no department-like structure. The school has an atmosphere, almost a "mission," which encourages freedom for a project such as the CNP project to develop in its own way. Utilizing a pass-fail grading system, and having no hard and fast requirements regarding courses to be taken, the school allows flexibility, and encourages each student to pursue his or her goals in an individual manner.

Both facilitation and constraint were found in this setting. An evaluation committee (an advisor and two other faculty) determines when the student has met the requirements of the school and may receive the M.P.H. degree. Each student was assigned on a random basis to an evaluation committee. One member of our staff, because of his full faculty status, was the only project staff to participate as a member of an evaluation committee. Although the CNP course sequence was a major focus for the CNP preparation, a documentation of the process has not been accepted by all evaluation committees as an acceptable master's project topic. (In the first year some students were told that a description of the process, community involvement, etc., was not scientifically rigorous enough. The following year when a student wished to document the process as she had experienced it, she was advised not to since it had "already been done.")

The third component of the framework, the subject, is the focus of the remainder of this chapter. Broadly stated, the subject of the CNP curriculum is the application of the nursing process in the community through a community development approach.

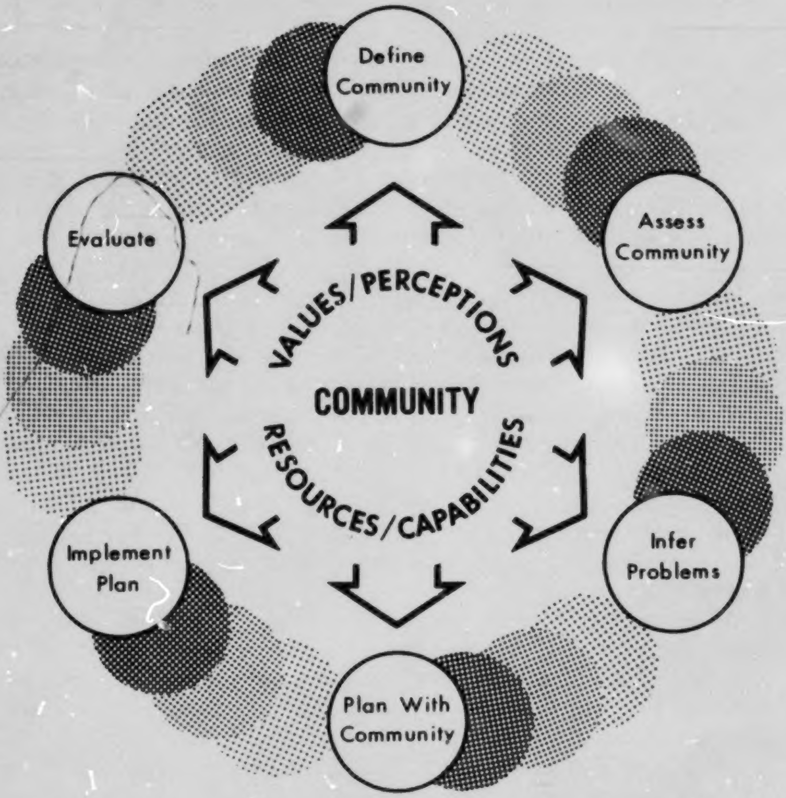
Briefly, the nursing process for the CNP role revolves around and is concentrated on the community. This focus takes into account not only health problems, resources, and capabilities, but also its values and perceptions in all phases of the process. A diagram of the process is included as figure 1 to illustrate the community focus.

To clarify the CNP role and point up some of the differences between it and the family nurse clinician role, see table 1.

Table 1.—Comparison of community nurse practitioner and family nurse clinician roles within the nursing process framework

	Community nurse practitioner	Family nurse clinician
Primary focus	Community	Individual/family
Secondary focus	Individual/family	Community
Inferences	Assessment of community-oriented health record	Assessment of problem-oriented patient record
Intervention (Planning and implementing)	Identify community priorities and objectives Mobilize resources, individuals, groups in self-help endeavors Organize groups to effect increase in knowledge of health-affecting practices	Identify patient priorities and objectives Manage diet, drugs, exercise and overall therapeutic program Teach patient and family
Evaluation	Identify appropriate and effective measures to meet community objectives Identify indicators of improved health status	Identify appropriate and effective measures to meet patient objectives Identify indicators of improved health status

Figure 1.—The community nurse practitioner process


Define Community
Assess Community
Infer Problems
Plan With Community
Implement Plan
Evaluate
VALUES/PERCEPTIONS
COMMUNITY
RESOURCES/CAPABILITIES

From the components of the conceptual framework (the students, setting, and subject), two principal objectives for the program were defined and later formed the basis of the curriculum:

1. To develop and strengthen attitudes and skills needed for working with community groups;
2. To strengthen analytical skills needed for assessment, analysis and evaluation.

To meet these objectives, as well as the students' individual needs, the process of developing courses in the CNP program was an interactive one, as mentioned previously. Students were involved from the first in helping to define what content was needed, in evaluating the relevance of other courses in the School to the CNP program, and in defining needs and gaps, as well as strengths of the courses, for future students. Development of attitudes and skills in working with community groups was approached through the fieldwork component and will be discussed in the second part of this chapter.

The CNP seminar was one of four courses required each quarter for nurses in the program. The other three courses were chosen from those available at the school and often included an "individual study" course. Objectives for individual study courses were defined by the student with the help of a faculty advisor. Many of the nurses in the program used this mechanism to choose other courses that focused on CNP-related activities, such as community involvement.

Evolution of the three-course CNP seminar sequence is depicted in table 2. As can be seen from table 2, the process was somewhat shortened and compressed from the first to the fourth year. For example, students in the first year of the program were identifying a community problem during the third quarter, while students in the fourth year were beginning some kind of intervention by that time. Appendix A provides information on the content of the courses, including a sample outline with objectives and a list of some of the recommended reading for each of the three major topics covered: community assessment, analysis and planning, and intervention.

As a result of identifying the first group of students' needs, a preschool workshop was built into the curriculum for the second and third year. The workshop served nurses coming into the program in two ways: as a bridge into student life and as an introduction to the CNP role. The students overall reactions to the workshop were quite positive, since it gave them a head start into the program. An overview of the workshop is included in appendix A.

The courses that made up the students' curriculum are listed in table 3. Included in the list are the number of students who

Table 2.—Summary of changes occurring in focus and sequence of seminars for CNP students, 1972–76

Quarter	1972–73	1973–74	1974–75	1975–76
1	Selection of community	Selection and involvement	Selection, involvement, assessment	Selection, involvement, assessment
2	Assessment and problem identification	Assessment and problem identification	Analysis and planning	Analysis and planning
3	Involvement and further problem identification	Analysis and planning	Intervention, secondary assessment	Intervention

Table 3.—Summary of courses taken at the School of Public Health by 21 CNP students, 1972–76

Course	Number of students in course	Course	Number of students in course
CNP Seminar II	21	Community Mental Health	2
CNP Seminar III	21	Health Aspects of Urban Design	2
Bases of Community Health (Core)	21	Sociocultural Factors in Health	2
Biometry I	20	Alcohol Abuse in Public Health	1
Epidemiology	20	Applied Anthropology	1
CNP Seminar I	20	Child Abuse	1
Program and Policy Planning I	10	Demography	1
Introduction to Health Services	8	Environmental Health	1
Biometry II	6	Ergonomics	1
Management Methods	6	Health and Society	1
Program and Policy Planning II	6	Health Aspects of Urban Design II	1
Applied Epidemiology	5	Health Education	1
Child Health, Growth and Development	4	Natural History of Disease	1
Communication for Public Health Workers	4	Nutrition	1
Health Department Management	4	Politics of Health	1
History of Medicine and Medical Care	4	Retirement	1
Public Administration	4	Rural Health	1
		U.S.-Mexico Border Health Problems	1
		Zoonosis	1

Note: All students additionally took other individual study courses, most of which were in the following areas: community health, community health nursing, community development, fieldwork, and data analysis.

took each course and the percent of all CNP students the number represents.

The curriculum to prepare nurses to function as CNPs may be summarized in key concepts that have been identified by staff and students over the past 4 years. These concepts are viewed as essential for inclusion in the curriculum and as valuable for inclusion in all phases of the preparation process.

Key Concepts:

1. *nursing process*—the methodology of nursing which identifies it as a problem-solving process (assessment, problem identification, planning, implementation, evaluation).
2. *community development*—a process which parallels 1, above, but has as its base the community, and as its goal, the development of that community to solve its own problems.
3. *self-health*—applying the processes (1 and 2) to health—a goal of each process wherein individuals and communities are capable of making informed decisions and carrying out appropriate actions to improve their health.
4. *cooperator in change*—the CNP's role in the community. By applying the processes described and working toward self-health, the CNP becomes a cooperator rather than an agent of change.

Fieldwork

As indicated elsewhere, the CNP program focuses on an entire community and the development of skills directed at the assessment and amelioration of community-wide health problems. In order to achieve these objectives, the program has, from the very beginning, relied heavily on the fieldwork component of the three-course sequence of CNP seminars. While the fieldwork experiences of each student have varied, as have the emphases given to different aspects of the CNP educational process, every student's fieldwork has been guided in accordance with the basic principle of the Roger Harrison Learning Model—a model used extensively by the Peace Corps in preparing their volunteers.

The model is basically an experiential process in which students, staff (faculty) and communities are involved in a joint effort to:

- Develop the CNP's ability to *come to conclusions and take action* in the community involved, even though the CNP may not always possess the ideal information.
- Search for possible courses of action and viable alternatives.

- Work with those who are actively concerned toward limited, concrete goals, important to them.

As can be readily seen, the goals of university education often conflict with such pragmatic, reality-based objectives. It has been the authors' experience, however, that students can be assisted in integrating the theoretical aspects of their education within a School of Public Health with the more practical aspects of their community experiences. This has been the challenge to the CNP staff and students.

As a result of using this model, students were not only assisted in working through their own definitions of community, their values and assumptions about community work, including their fears about different communities, but also were encouraged to develop an individual style and community work role with which they would be most comfortable. In addition, students were not preassigned to the communities in which they would work, but were aided in developing criteria on which to base their selection of a fieldwork community. Criteria varied from student to student, but some criteria common to all were:

Size of community
Distance of community from student's home and/or school
Ethnic composition of community (Was it the same as the student's?)
Language spoken by the majority in the community
Issues present in the community
Degree of militancy present within the community
Degree of community organization present
Number and type of agencies present in the community
"Feel" of community to student
Goals of student relative to community experience

Over time, various methods of assisting the students to "get their feet wet" in the different communities were developed by the project staff. These included the preselection of a group of communities, varying in composition, location, issues, etc., to which the students were introduced in a step-by-step means of different community-based exercises and assessment guides, plus frequent debriefing sessions. Since the selection of a specific community in which to work for the entire year often presented considerable problems for students, it became the staff's responsibility to assure them that sufficient learning experiences would be available in all communities, and that the success of their academic program did not depend solely on this one decision.

Some of the communities eventually selected by the students and in which they attempted to implement the CNP process were:

6 Predominantly Mexican American communities
6 Predominantly black communities
3 Triracial communities (black, white, Mexican American)
1 White academic and professional community
1 Rural county
1 Counterculture drug facility
1 Model-Cities Day Care Center
1 Mass-based community organization of 50 different groups.

Within these different communities, the roles played by the CNP students frequently varied in accordance with the communities' needs, the students' abilities, and the resources available, but one role encouraged of all students was that of cooperator in change. The communities in which the students worked were not looked on as targets of the students' efforts, but as partners in the change process.

To look at other aspects of the different roles played by the CNP students, it may be helpful to utilize a framework, developed by Dr. Jack Rothman,[1] to distinguish the different models of community organization practice by their selected practice variables. The three models by Rothman, and to which all CNP students were exposed in their seminar and fieldwork experiences, are locality of community development, social planning, and social action. Rarely seen in pure form, the model most frequently used by CNPs was a combination of community development and social planning with both task and process goals. While problem-solving with regard to substantive community problems was frequently a major goal, the process goal of increasing the community's capacity and integration by means of self-help was more often paramount.

Two basic change strategies utilized by CNP students were attempts to involve broad crosssections of people in determining and solving their own problems, and gathering facts about problems and assisting in decisions on the most rational courses of action. As the CNPs worked either with small task-oriented groups or the manipulation of data, the different practitioner roles they played were those of:

Enabler/facilitator/catalyst
Fact-gatherer/analyst
Planner/rational problem solver

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[1] Rothman, J. "Three Models of Community Organization Practice." In *Strategies of Community Organization: A Book of Readings*, edited by Cox, F. M., Erlich, J. L., Rothman, J., and Tropman, J.E.F.E. Peacock Publisher, Itasca, Illinois, 1970.

Advocate (being on the outside)
Linker/connector (within and without)

At no time did CNPs function within the social action model, with its emphasis on power relationships and the crystallization of issues, in order to organize community groups to take action against the "enemy." However, had the students been able to remain for a longer period of time in specific communities, it is probable that some definite positions would have been taken in opposition to local governmental units or agencies. Decisions were always made to stop at this stage in the CNP process due to the realities and constraints of the student role and the commitment that would have been involved in both time and effort. In addition, there was a fear that without this commitment, over time, the communities would have been in danger of exploitation by the CNPs and possibly left in a worse condition than previously.

Problems identified by the communities and the CNPs working in them rarely related to the traditional services offered individuals by nurses in official health agencies, i.e., immunizations, well-child clinics, family planning, et cetera. Instead they were community-wide problems, such as:

Environmental Problems—

Flood control, access in and out of their communities
Drainage, rat control, vacant lots, solid waste disposal
Street lights, fire protection, poor housing, abandoned housing

Psychological Problems—

Powerlessness, alienation, drugs, loneliness of young and old
School absenteeism, school dropouts

Economic Problems—

Limited financial resources, unemployment, underemployment

The problems, identified on a community-wide basis, had been previously thought of by the CNP students as outside the domain of a public health nurse. Yet, as they asked the communities about their problems and began to analyze them, looking at the various links and how they affected the lives of the individuals living in those communities, it soon became apparent to the CNP students that dealing directly with these same problems would be one means of ultimately affecting the health status of the communities and the individuals in them.

Throughout this process of problem identification and analysis by the students, the staff attempted in both seminars and individual conferences to assist in integrating the theory learned by the students in their UTSPH course with the practical realities encountered in their community experiences.

Although the project staff had always envisioned the CNP role as being appropriate for official public health agencies, the first three groups of students worked only with various community groups, such as those sponsored by different religious denominations, parent organizations, homeowners, and concerned citizens. Such a loosely affiliated manner of working in a community had some advantages for the students in that they were not hampered by agency policies and guidelines, which left them free to develop the CNP role as they wished. Additionally, they were not troubled by a possible negative image of an agency in the community. However, having an "official" reason for being in a community, plus the resultant freedom of lack of structure, often caused problems for those students who required a considerable amount of direction in their community work. The staff continually attempted, within the limits of the Harrison Learning Model, to provide the needed structure, but this element of the CNP curriculum continually caused difficulties for some students.

As sufficient contacts were made with personnel from the nursing departments of both the city and county health departments, it became possible for student CNPs to have their fieldwork experiences while being loosely affiliated with official public health agencies. In practice, however, the majority of students remained more connected to the project and other community groups than the health departments. In one instance—the county health department—the nursing directress met regularly with some of the CNP staff and a CNP student to develop means by which student and graduate CNPs could function effectively within the official agency.

The impact the student CNPs had on the health status of the various communities in which they worked is extremely difficult to measure, especially if this is attempted in terms of morbidity and mortality rates or in total immunizations or services provided. Keeping in mind that the students' principal reason for being in the communities was to develop and strengthen attitudes and skills needed for working with community groups and to strengthen the analytical skills needed for assessment, analysis, and evaluation of community problems, it should be evident that the amount of time required for the lengthy process of improving a community's health status through the utilization of such indirect means was not available to the students or the project. While the time spent by the different students in their communities varied from student to student and from week to week, it is doubtful whether any student spent on the average more than 8 hours weekly in his or her community.

Even given these conditions, attempts were made from the very beginning of the project to build into each student's efforts in a community some degree of continuity, so that what had been begun would not cease once the student left the community. Students were encouraged to leave behind them, whenever possible, some group or groups with sufficient energy and ability to continue in their problem-solving efforts. Unfortunately, however, the student year has frequently been barely sufficient to build the ground work for such community undertakings. As the project has learned with those graduates who have remained with the project, the "payoff" usually comes later, at a time too late for most of the CNP students.

In those few instances where the CNP graduates have remained over time, there is evidence that the various communities involved have increased their competence in:

looking at their problems;
bringing their own and others' resources to bear on these problems;
capitalizing on their own strengths;
linking themselves to other groups within and without their community.

Fortunately, for the CNP project, one or more of these graduates has been available part of each year to assist CNP students in learning all the phases of the complete CNP process. (Further description of the fieldwork experiences can be found in Chapter 4, Community Outcome Analysis.)

Chapter 2

COMMUNITY NURSE PRACTITIONERS: THE GRADUATES

Introduction

This section relates to those who completed the sequence of courses which made up the Community Nurse Practitioner Program. Although not all have actually received the M.P.H. degree, the group will be referred to as graduates of our program.

Following a brief description of the graduates, this section is further composed of three parts: a summary of all master's projects written by the graduates; a discussion of the staff's perceptions of the graduates as students; and a review by the graduates of the CNP Program and their experiences in it. Additionally, the graduates' evaluations include answers to questions about the type of work they are engaged in at the present time.

A total of 25 nurses enrolled in the CNP Program during the 4 years, 1972–1976. All but two entered with a baccalaureate degree in nursing. Twenty-one completed the program.

Ages ranged from 24 to 56 with a mean of 32; however, a 56-year-old nurse dropped out of the program during the first quarter of the first year; so the mean age of graduates is somewhat lower. Other demographic information is included in table 4.

Of note in the summary above is that although 21 students completed the sequence of courses, 15 were actually graduated from the school. This discrepancy is primarily due to the master's project requirement discussed below.

Master's Projects

Requirements for a Master's of Public Health degree from the University of Texas School of Public Health include the completion of 12 courses of study plus the presentation of a master's project that demonstrates "a substantial knowledge of community health." [1]

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[1] UTSPH Catalog, 1975–76, p. 21.

Table 4.—Demographic characteristics of students enrolled in the CNP Program, 1972–76

	Number	Percent
Total number in program	25	100
Previous baccalaureate degree in nursing*	22	88
Sex:		
Male	2	8
Female	23	92
Race:		
Black	3	12
Spanish surname	1	4
White	21	84
Home State:		
Texas:		
Houston	17	68
Other	2	8
New York	1	4
Wisconsin	1	4
Washington	1	4
Oklahoma	1	4
California	1	4
Tennessee	1	4
Marital status:		
Single	9	36
Married	14	56
Divorced	2	8
Attrition:		
1972	3	12
1975	1	4
Successfully completed CNP sequence of courses	21	84
Completed all requirements for M.P.H.	15	64

* Other degrees were: one in sociology, one in health education. One student had no degree.

There are few established guidelines for determining the appropriateness for the area of concentration for the master's project. The project topic is selected by the student in conjunction with a committee of three members of the faculty who form the student's evaluation committee. This committee monitors the student's progress on the master's project as well as his academic progress. Each member of the committee approves the awarding of the M.P.H. degree based on whether all requirements, including those for the master's project, have been successfully completed.

Although these projects have taken many forms (including health education and media projects, community work, and epidemiological studies), there is a tradition that the project be submitted in written form to the student's evaluation committee.

Of the 21 students who completed the Community Nurse Practitioner Program, 15 submitted a master's project for approval and subsequently received an M.P.H. degree. During the first year of the CNP project there were six students. All wrote a report of a master's project and were graduated. One student, from the second year's group of five students, and two students from the third year's group of six students have yet to write a project report. Personal considerations have prevented two of these students from finishing. One other student was prohibited by her committee from documenting her community experiences. She has yet to agree on a project focus with her committee. From this last year's group of four students, one was graduated and one other is in the final stages of writing the report of her project. Not enough time has elapsed to determine whether the other two students will have a master's project approved in the near future.

Community nurse practitioner students, already involved in intensive fieldwork, generally had the option of focusing their master's project on some aspect of their community work. Some students were directed by their committees to write on a limited part of their work, such as community assessment. With the exception of one student who wrote on the historical development of public health nursing, all wrote on some aspect of their community experience to document all or part of the community nurse practitioner process as presented in the seminars. This process included assessing the health of the community and developing a community problem list based on demographic data, observation, and community input; analyzing one community health problem to determine intervention points; planning to intervene in the community, using and strengthening community resources whenever possible; working with the community to implement the plan; evaluating the outcomes of intervention; and providing for continuity of intervention in the community when the CNP leaves.

A total of 14 community experiences are documented in the master's projects. Two projects focused on creating a community profile and on assessing the health of the community. Both developed community health problem lists based on resident input through some type of survey. One of these assessments is exceptionally thorough. Another master's project began with the analysis of a problem affecting a limited sector of a community—volunteer fire-fighters. A plan to reduce coronary heart disease among these workers was presented in this project.

The remaining 11 projects all attempted to document the entire spectrum of community work undertaken by the students. They described, to varying degrees, some involvement with community residents. All students had some interaction early in the community assessment phase of the process. Students received input from the residents by conducting surveys and personal interviews, and by attending community meetings. Four of the 11 projects were outstanding in their description of interaction with the community throughout the entire community assessment phase. Another three projects depicted good interaction with agencies serving the community. The remainder of the projects were limited in describing any community interaction past the assessment phase.

All 11 projects presented a demographic profile of the community under study and an assessment of the health of that community. Four of these projects were especially thorough and informative. Only one of the 11 students limited her assessment to a small portion of the community population.

A wide range of community problems was identified and described in all but one of the projects (the exception was the project with the very limited assessment). They ranged from environmental and housing problems to community discouragement and apathy. Problems affecting adolescents (school dropouts, drug abuse, delinquency) were cited in four of the projects. Limited or inaccessible health care resources were found to be problems in 7 of the 13 projects that presented a community assessment and problem list.

Eleven projects included an analysis of one community health problem. Problems analyzed were high rates of coronary heart disease among firefighters, high suicide rate, defeatism, environmental hazards, poor nutrition, delinquency, excessive rats, excessive school absenteeism, secondary school dropouts, and raw sewage in drainage ditches. One problem analysis of a high suicide rate was exceptionally well done. Five others were complete enough to permit the development of a realistic intervention plan.

Twelve projects presented an intervention plan. One plan to reduce mortality from suicide attempts was exceptional. Seven of the projects ended with the plan. Of the five projects describing implementation of the plan, three were written by students who spent more than the mandatory 9 months in the community. These were among the four students whose projects depicted extensive community involvement and interaction throughout the experience.

Only one project contained an evaluation of the intervention, a particular strength of that project.

Table 5 depicts the contents of the projects as reviewed according to the community nursing process. The projects generally illustrate the focus of the student's efforts in the community and the extent to which the student experienced the entire process.

The exceptional sections of the projects are marked by an asterisk. There is evidence of strength in most. Five contain superior community profiles and assessments. One has an exceptional problem analysis and intervention plan. Two depict extensive community interaction, and three document implementation of a plan. One presents a good evaluation of the intervention. The strength of one of the two community studies is in the innovative manner in which the CNP has arranged for the use of survey information by a clinic serving the community.

Many CNPs had neither time nor energy to attempt to implement their plan, as evidenced by the fact that only five of the master's projects document that stage of the process. The 9-month academic program may have been too short to permit any but the most involved students to reach this phase in the process.

Staff's Perceptions

In attempting to identify what might be predictors of successful student performance in the CNP program, and later success in implementing the role, staff members deliberated over what the key factors seemed to be. Seven factors were agreed upon and are discussed below.

1. *Community involvement.* How involved in the community was the student? Is there evidence the student spent adequate time with the people in the community? Did the student contribute descriptions or examples of his own experiences in the community during seminar discussions? Was the student a participant in the community?
2. *Understanding role.* In written and verbal communication, did the student demonstrate comprehension of the major elements of the role? Could she describe the role to others?
3. *Academic contributions—seminars.* Did the student bring meaningful contributions to the classes? Did he come to classes prepared to discuss the topics to be covered? Did he/she turn in papers that reflected thought and preparation? Was the student actively involved in the CNP seminars?
4. *Masters' projects.* How well does the master's project reflect the CNP process? Is the project well written and fully documented? Does it reflect involvement in the CNP program?
5. *Poise, presence, self-confidence.* Did the student communicate these attributes in the seminars? In the community? Did she develop them while a student in the project?

Table 5.—Content review of the master's projects written by community nurse practitioners

Student number	Kind of study	Community interaction	Profile and assessment	Problem list	Problem analyzed	Intervention plan	Implementation	Evaluated	Provision for continuity
109	Historical review of PHN								
112	Community study	Observation interviews committee mtgs.	*×	×					
118	Study of clinic & service area	Survey of clinic users in neighborhood	×	×					
111	Planning study				×	×			
115	Community study	Agencies	*×	×	×	×			
107	Community study	Residents community organization	*×	×	×	×			
117	Community study	Limited	×	×	×	×			

108	Community study	Limited	×	×	×	×			
110	Community study	Limited	*×	×		×			
102	Community study	*Extensive	×	×	×	×	×		*×
105	Community study	With elem. school	×	×	×	×	×		×
116	Community study	*Extensive	*×	×	×	×			×
113	Community study	*Extensive	×	×	×	×	*×		*×
114	Community study	Community center	×	×	*×	*×	×		×
103	Community study	*Extensive	×	×	×	×	*×	*×	×

* Area of strength in the project.
(×) = present in project.

6. *Staff's confidence in the student's competence.* How do the staff feel about the ability of the student to carry out the concepts learned in the CNP program? Do they feel he will continue to work to implement and refine the CNP role or will he return to a position similar to that held before coming to the School with essentially the same tasks?
7. *Commitment.* Does the student demonstrate that she feels an obligation and devotion to the concepts inherent in the CNP role? Will the student remain loyal to these concepts in the face of pressures from institutions, peers, and others?

To test whether the staff members perceived these variables in a similar manner, and to evaluate the students who came through the program, the variables were utilized in the following way.

Each staff member independently ranked each CNP against all other CNPs on each variable. Additionally, the CNP was given a score, independent of other CNPs, for each variable. The individual scores that were assigned were based on a continuum where five was the highest (best) possible score for each variable and one was the lowest (worst).

Impressions

Individual Rating.—Each of the 17 CNP students was rated on the 1- to 5-point scale on each of the 7 identified variables. Figure 2 depicts frequency distributions for each variable.

CNPs are fairly normally distributed in the ratings for most of the variables. A skew toward the higher end of the scale is evident in the variables relating to understanding the role and self-confidence. Staff assigned the fewest high ranks (five) to commitment which is, at best, one of the most subjective and difficult to evaluate variables.

Overall Rank.—In ranking the CNPs against each other, and being forced to place them on a continuum of from 1 to 17 (1 as the highest), staff members show a high degree of agreement. To compare overall ranks which were assigned by each staff member, the rank for each student was averaged and plotted by three staff members. This is depicted below in figure 3.

As one would expect, the closest agreement among the staff was with the ranking of students at both extremes: outstanding and poor. A bit wider spread appears among ranks of the CNPs who are closer to the middle. Apparently staff members not only agreed on the listed criteria for success, but, despite limited definition, agreed on certain attributes that went into defining those criteria.

Figure 2.—Frequency distributions of average individual ratings for each variable

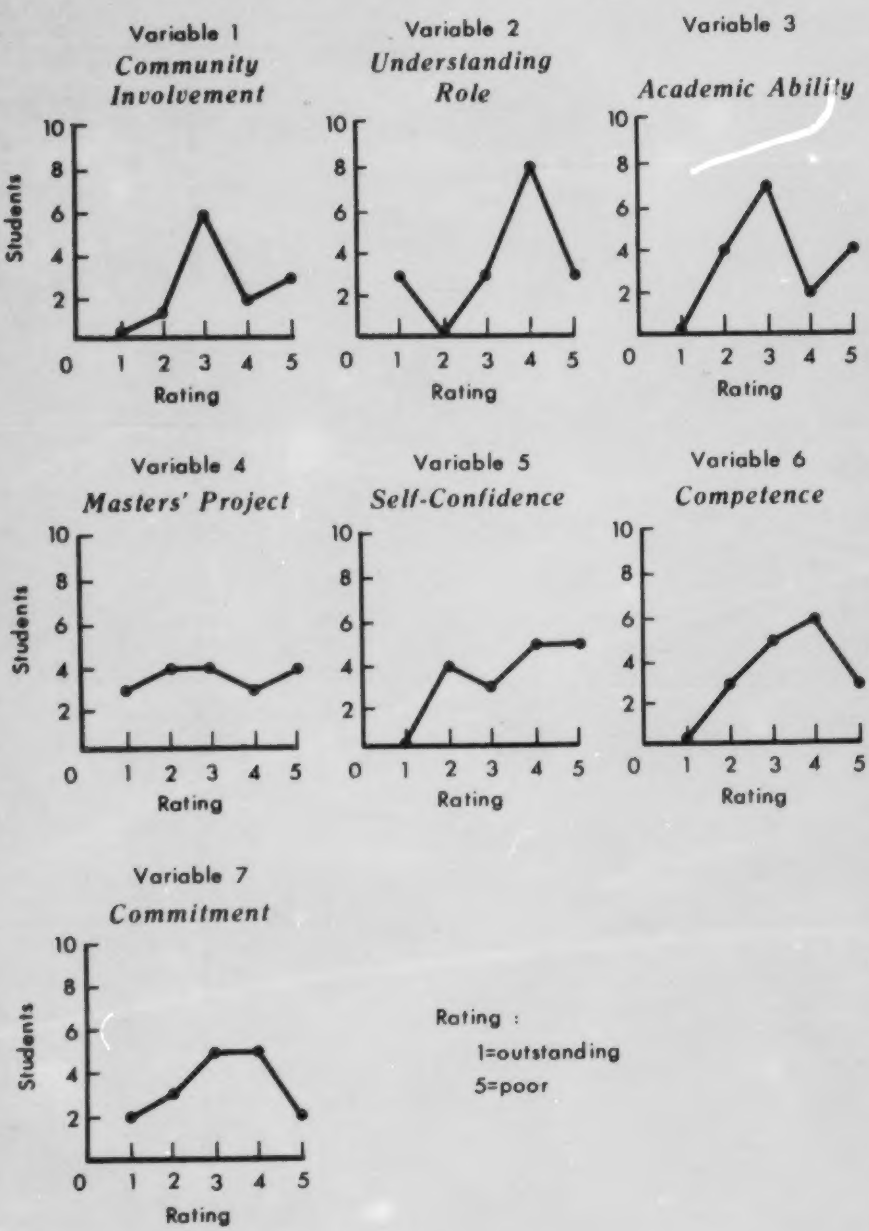
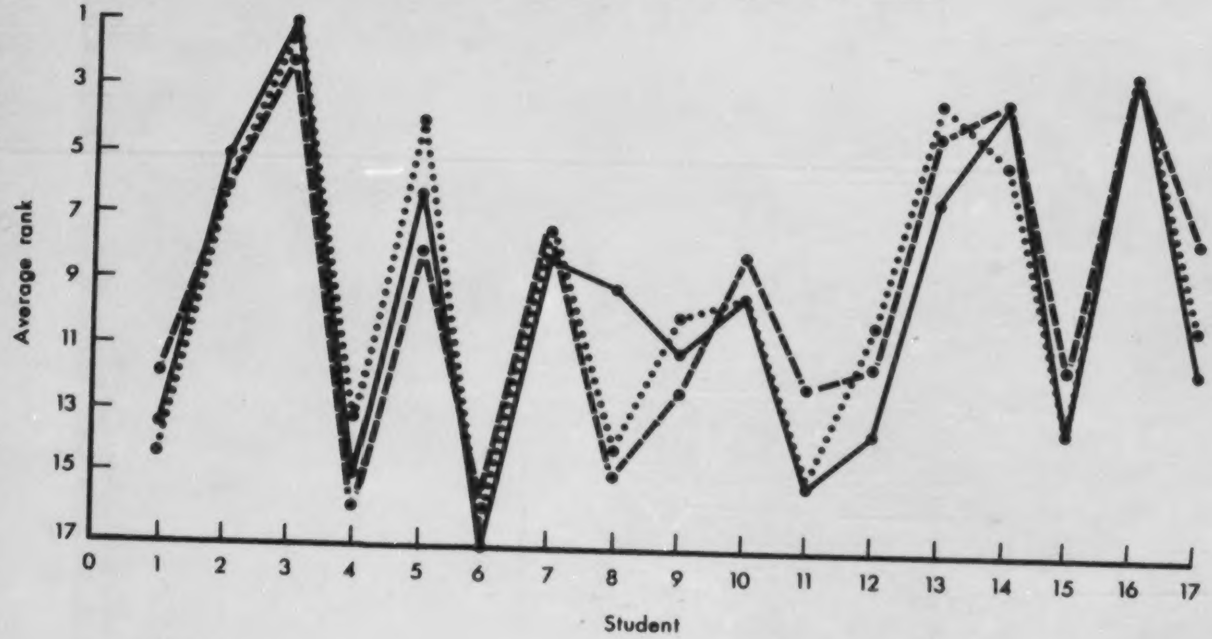


Figure 3.—Average rank of each CNP by three staff members



Individual Rank.—In addition to looking at overall ranks based on an average of ranks of all seven criteria, the staff were interested in differences between their rankings on each variable for the individual CNP. These also were plotted and follow as figure 4. They depict how each staff member ranked each student on each variable.

As in the overall ratings, it was evident (and expected) that there was closest agreement among staff on the outstanding CNP and on the "lowest ranked" CNP in terms of the seven variables. Where there was rather marked variation in ranks, the direction was usually consistent among the rankers. For instance, student 1 was ranked 4, 8, and 11 on variable 5. This reflects a rise for each of the raters who ranked that student 14 for the preceding variable. Additionally, some of the variation was no doubt due to personality differences wherein one staff member may have had more positive or negative feelings about certain students.

That there appeared to be rather consistent agreement concerning student ranks points to the value of this exercise. From this beginning it was a short distance to the development of well-formulated and meaningful behavioral objectives for the educational program. And from these objectives one may begin identifying specific outcomes that allow measurement of the effectiveness of the program in imparting the needed knowledge, skills, and attitudes, as well as the success of the student in learning and applying them.

Not only would the objectives enhance the student's learning by providing clear guidelines, but they would also allow for more relevant evaluation. In this manner, then, the faculty would have the advantage of a reliable feedback mechanism, along with the defined accountability to the students for the implementation of the educational program.

Project Evaluation

To look at the CNP project from the students' and graduates' perspectives, the staff developed a questionnaire (see appendix B) and mailed it to each of the former students. Also sent was a letter informing them that they would be contacted by phone for followup and further questioning. A list of the telephone questions are included in appendix B.

Responses to the questionnaires were compiled and analyzed and are presented in figure 5. The questions are also included in figure 5 and are repeated preceding the discussions to assist the reader.

How aware were you of the objectives of the CNP program during your time as a student in the program? and *How relevant (ap-*

Figure 4.—Industrial rank of 17 students for each of 7 variables by 3 staff members (1=highest rank)

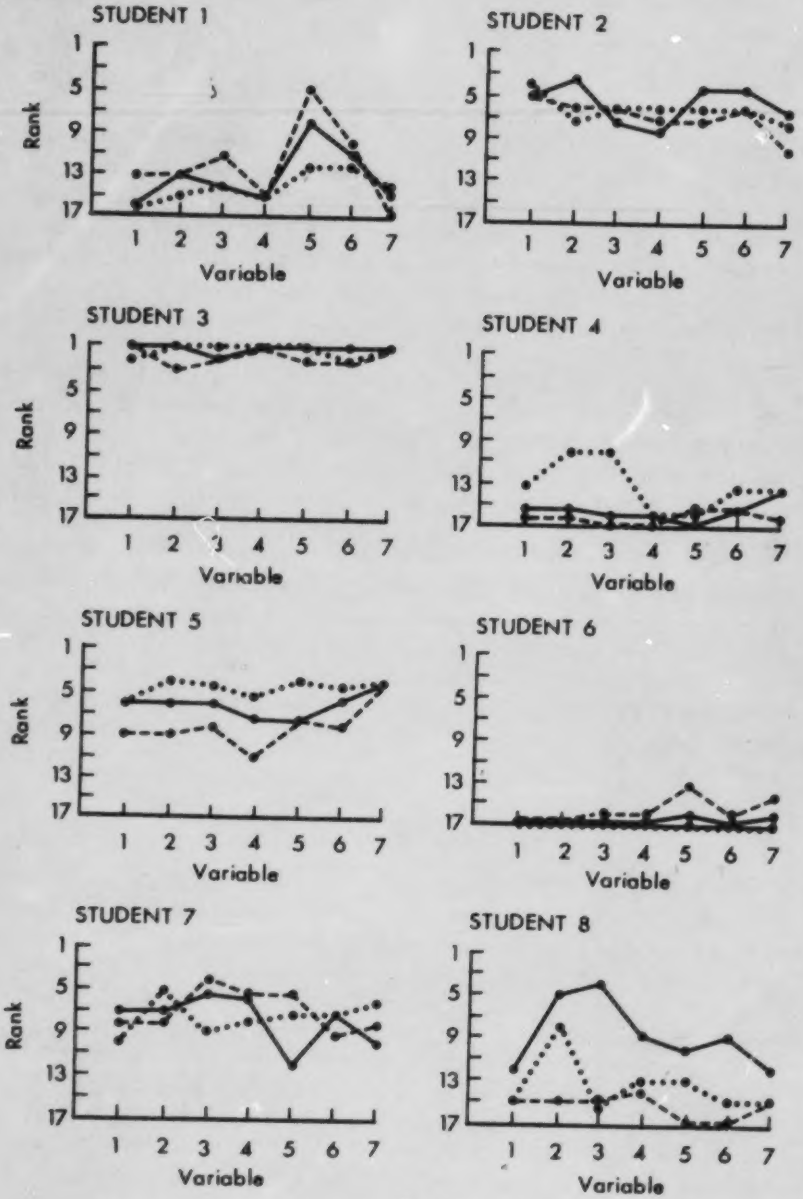


Figure 4.—Industrial rank of 17 students for each of 7 variables by 3 staff members (1=highest rank)—Continued

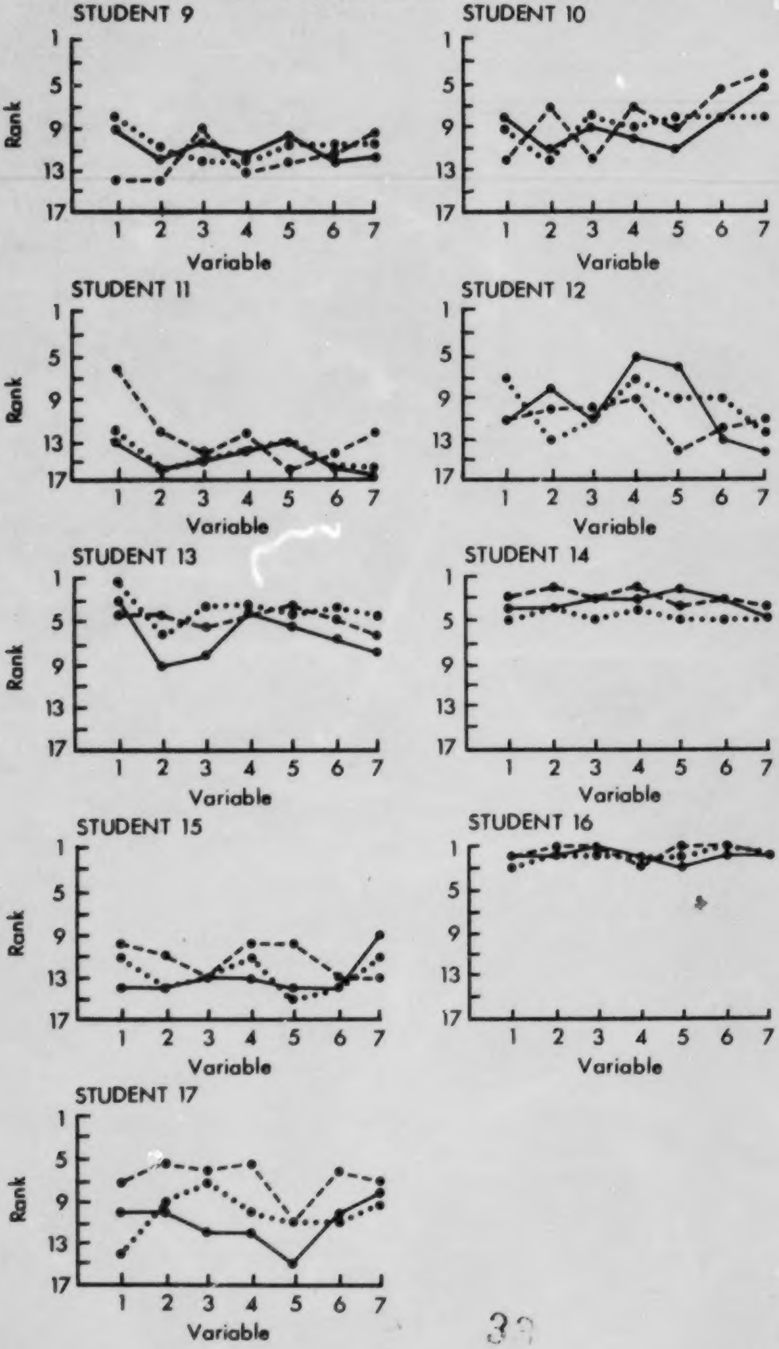


Figure 5.—Respondents' indications of the extent of their awareness of and the relevancy of the objectives of the CNP program, during their time as students, by number and percent

Objectives

1. Analyze the role of the CNP in relation to:
   a. Community health nursing theory and principles;

   b. Community development/organization theory and principles.

2. Gain entry to one specific community (geographic or otherwise) and, as a result of personal interaction with its members, demonstrate in written form a beginning perception of the community's:
   a. Dynamics (emphasis on internal workings);

   b. Observable characteristics;

   c. Relationships (emphasis on external);

   d. Needs--expressed and inferred.

3. Synthesize available data to draw inferences about the health status of the caresphere and to develop a list of the community's problems.

4. Analyze the role of the CNP in relation to the caresphere.

5. Analyze one real or potential health-related problem which has been identified in the community by
   a. Defining as precisely as possible the nature and extent of the problem, as well as its priority to the community;

   b. Describing and documenting the various factors which contribute to the existence of the problem.

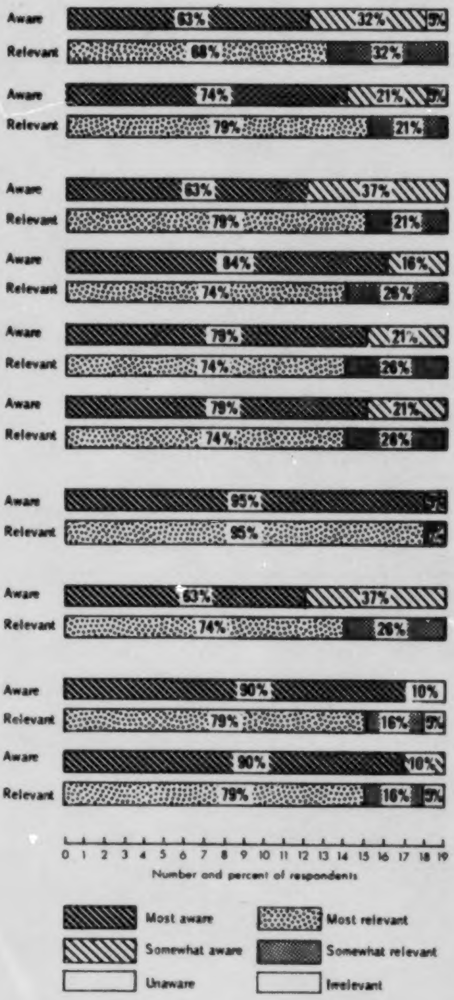
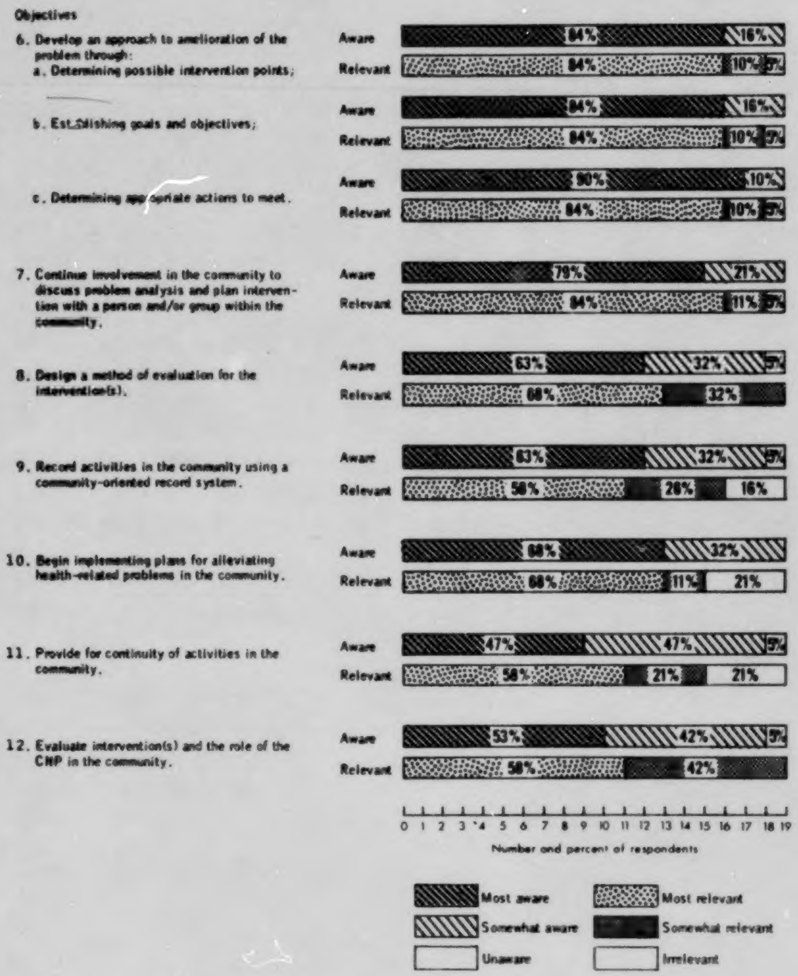


Figure 5.—Respondents' indications of the extent of their awareness of and the relevancy of the objectives of the CNP program, during their time as students, by number and percent—Continued



propriate) were each of these objectives to your learning needs as a student in the program?

As can be noted in figure 5, 74 to 95 percent of the respondents indicated they were very aware of objectives 1b, 2, 3, 4, 6, and 7. From 47 to 68 percent indicated they were very aware of the remainder of the objectives.

The majority (74 percent-95 percent) of respondents indicated they were very aware and believed the following orientations most relevant: synthesis of available data; analysis of a health problem; perceiving the community's external relationships, observable characteristics, internal dynamics, and needs; discussing problems with community members; developing an approach to ameliorate the problem; and analyzing the role of the community nurse practitioner in relation to community development/organization theory and principles.

Lower percentages (47 percent-68 percent) indicated they were very aware and believed the following orientations most relevant: implement plans for alleviating problems; record activities utilizing a community-oriented system; design a method of evaluation of intervention(s); evaluate intervention(s); analyze the role of the community nurse practitioner in relation to community nursing theory and principles; provide for continuity of activities in the community.

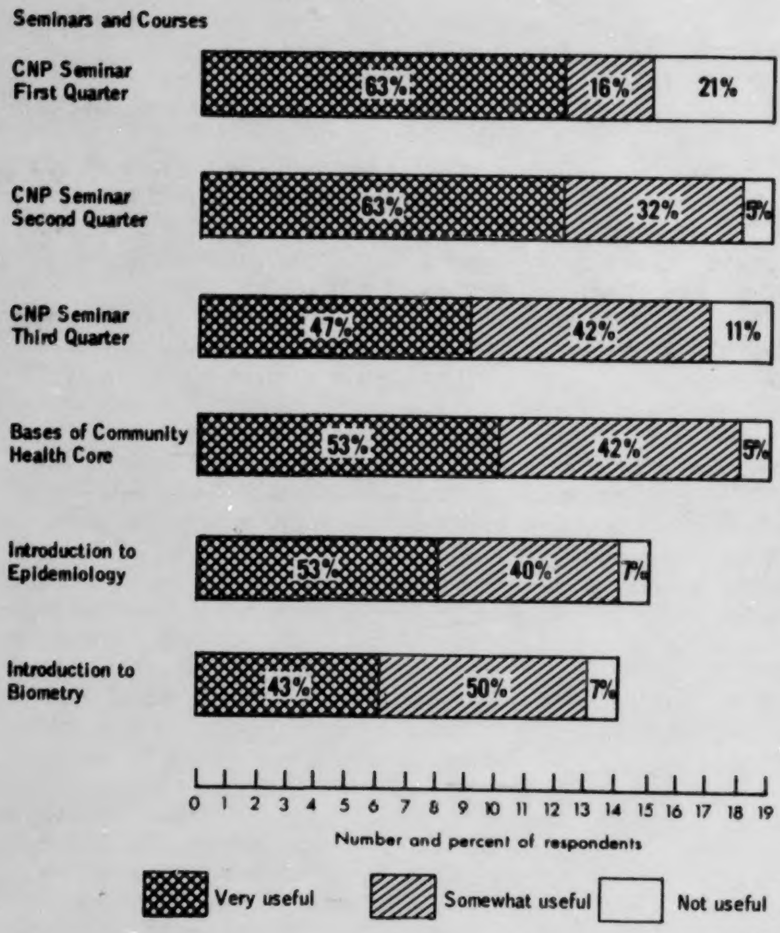
Four respondents indicated two objectives were irrelevant to their learning needs: (1) Begin to implement plans for alleviating health-related problems in the community; and (2) Provide for continuity of activities in the community.

Three persons indicated one objective to be irrelevant: Record activities in the community, using a community-oriented system.

That the majority of the students either were not aware or did not find certain objectives relevant may be due to several factors. One, these objectives were developed over the years and actually reflect a culmination of the staff's thinking, therefore, early students would not have been exposed to them. Additionally, although the objectives may have been made explicit, the students did not always complete the entire process. That is, due to time or whatever constraints that may have been imposed, they often did not get beyond initial assessment of the community, analysis of a problem and development of a plan. That providing for continuity and evaluating plans were not seen as relevant, again, seems to reflect that the students just did not reach those points in the process.

Responses to the objective which relates to a community-oriented record system may well reflect some of the difficulties. *Please indicate the usefulness of the classroom (theoretical) experiences in*

Figure 6.—Respondents indications of usefulness of CNP seminars and courses, by number and percent



relation to developing skills, knowledge, and attitudes basic to becoming a CNP.

The majority of respondents were of the opinion (see figure 6) that the Community Nurse Practioner Seminars taken during the first, second and third quarters were either very useful or somewhat useful: 79 percent, 95 percent, and 89 percent for each of the 3 quarters respectively. Of the 4 respondents (21 percent) who found the first quarter to be *not* useful, 2 were from the first year's class (1 did not take the first seminar) when the seminar served as a place to explore and refine the role definition.

The first quarter seminar was indicated by 63 percent of the 19 respondents as being very useful and 16 percent as somewhat useful.

The second quarter seminar was also indicated by 63 percent as being very useful; 32 percent indicated it as somewhat useful.

The third quarter seminar had the highest number of respondents, eight (42 percent), who indicated it as being somewhat useful. Nine (47 percent) indicated it was very useful.

It is difficult to speak about "the" CNP seminars as though each first quarter covered a certain amount of content and it remained the same from year to year. There was a great deal of variety in both the specific content covered in each quarter, as well as the method of presentation. This evaluation of the course sequence was described earlier in chapter 2 and will not be repeated here. However, it is note-worthy that, despite the changes and shifts of emphasis from one quarter to another, overall response to the question of usefulness was positive.

Three other courses are included in figure 6 because most of the students also were exposed to them and they were considered core courses in the School of Public Health. The Bases of Community Health was designed to "show the commonality of the many facets of community health, and to present an integrated view of the biological, physical, and cultural bases of health-related concerns."[2] This course was seen as very useful by 53 percent of the respondents and somewhat useful by 42 percent.

Introduction to Epidemiology and Introduction to Biometry were integrated into Bases of Community Health during 1975–76. Therefore, the number of students responding to the usefulness of these courses is lower, since this year's (1976–77) class did not take them as separately defined courses. The percent of students who indicated that they were either very useful or somewhat useful, however, is similar to responses to the same question about the CNP Seminars.

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[2] UTSPH Catalog 1975–76.

Fifty-three percent of fifteen respondents who took Introduction to Epidemiology as a separate course indicated it was very useful; 40 percent indicated somewhat useful, and 7 percent indicated not useful.

Forty-three percent of fourteen respondents who took Introduction to Biometry as a separate course indicated it was very useful, 50 percent indicated somewhat useful, and 7 percent indicated not useful. One respondent who took the course did not indicate an opinion.

Respondents took additional, elective courses, such as Program and Policy Planning (seven out of nine indicated very useful), Introduction to Health Services (one out of seven indicated very useful), Epidemiology second quarter (four out of six indicated very useful), Biometry second quarter (two out of six indicated very useful), Public Administration and Public Health, (all five indicated very useful). Thirteen other courses were taken by one or four respondents whose opinions varied from very useful to not useful. History of Medicine and Mental Health each had four respondents who took the course and each had two indicate them as not useful.

With the exception of what might be seen as essential content courses—the integrating CNP Seminars that include fieldwork, Bases of Community Health, Biometry, and Epidemiology—it appears that the other courses were selected on the basis of individual need and interest. It also appears, from the range of courses taken, that the School of Public Health is an appropriate setting in which to pursue education for the CNP role. Students have a great many and varied resources available to them in such an educational environment.

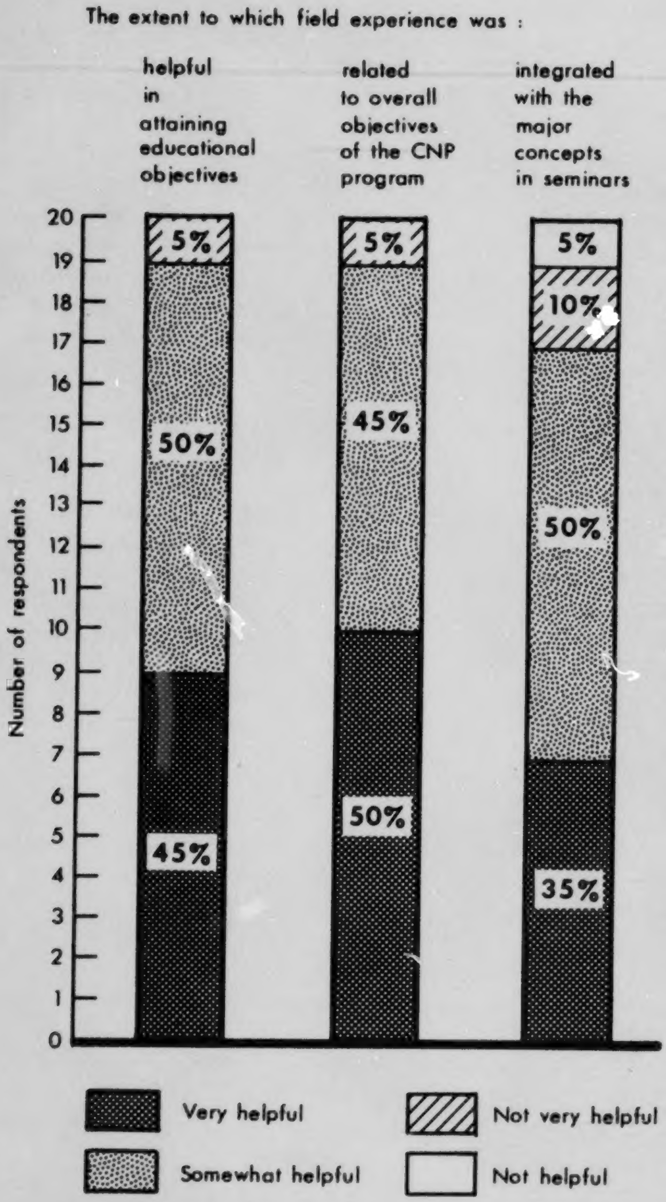
Please indicate the extent to which your field experience in your selected community was: (1) helpful in attaining your educational objectives; (2) related to the overall objectives of the CNP program; (3) integrated with the major concepts presented in seminars.

Responses to the above question are summarized in figure 7.

Ninety-five percent of 20 respondents indicated very helpful (45 percent), or somewhat helpful (50 percent) was their field experience in attaining their educational objectives. One person indicated it was not very helpful.

A total of 95 percent also indicated very related (50 percent), or somewhat related (45 percent) was their field experience to the overall objectives of the Community Nurse Practitioner Program. One person indicated it was not very related.

Figure 7.—Respondents responses to question relating to field experiences, by number and percent



A total of 85 percent indicated either very integrated (35 percent), or somewhat integrated (50 percent) was their field experience with the major concepts presented in seminars. Two persons (10 percent) indicated it was not very integrated and one (5 percent) that it was not integrated.

The fieldwork component is discussed in detail in chapter 2.

When asked about the fieldwork in the telephone interview, the respondents fell into two camps—those who did not think there should be any change and those who suggested changes needed. It was felt there might be a difference between the groups in relation to their own experience, or lack of it, in public health nursing. When looked at in this way, however, there was no definite division of these groups. Of the 11 respondents classed as having public health nursing experience, 5 wanted no change and 6 advocated change. Of the seven with little or no public health nursing experience, two recommended no change and five recommended changes.

Those who did not want changes made the following comments:

> No change. Students should start from scratch in the community, i.e., without prior faculty preparation.
>
> Working alone is the best way to handle communities. They accept one person more easily.
>
> No change. We spent a lot of time getting into the community. It's not absolutely necessary for faculty to accompany students on fieldwork.
>
> As is—let the students go out there and feel their way.
>
> This was done the way it should be, i.e., sink or swim may be the only way.
>
> Mine was great and I appreciated the freedom allowed by the faculty.
>
> Being able to select your own community and being able to do your own thing was the strongest feature of the program. This only works with certain types of people, and students selected should be able to work in unstructured settings.

Suggestions for change in the fieldwork experience are listed below:

> The setting should be designed for students in some manner similar to postgraduation status. Someone needs to work with and guide the students and follow through. At the beginning it would have been difficult for faculty to help, but once we had become involved with the community, then the faculty could have been helpful.
>
> It would be better to work with an agency or have all the students in one community. We could have worked in communities already set-up rather than 'virgin' communities.
>
> Agency association is very important. I have something (service) to give away which facilitated my egress and function. The nurse role gives a lot of credibility. There might have been fewer conflicts—which arose from feeling the staff couldn't grasp our problems—if they had been involved in the community.

I personally liked very much the freedom we had to choose our own community. On the other hand, perhaps there was not quite enough direction. Help from the faculty was kind of 'all or nothing.' Faculty might have had conferences with us in the community to see when we needed direction. The biggest drawback was the lack of experience of the instructors.

Having a CNP to supervise fieldwork was valuable. Field assistance is a valuable and needed addition.

Faculty and students together should be involved in an ongoing project.

More supervision for students who had this need.

I feel the time, courses, objectives, and fieldwork could have been more closely linked to the individual student and the community they were in.

It should be affiliated with an agency or some group. I was at a disadvantage because I had no 'handle.'

Unreal to get involved without going through an agency.

I couldn't understand how one could get into a community in a short time.

What criteria would you consider most important in choosing a community for a student experience?

Responses to this question were divided into two types: those relating to the community and those relating to the student. Of the former, seven students mentioned that there should be some agency or group already in exisence in the community; three specified some existing community organization. Those factors which may hinder a student's being able to spend adequate time in the community were brought out by five persons. These were accessibility, location, and distance to travel. Other factors mentioned once each were: manageable size, the hope of getting to know it, and "hope" or general viability.

In relation to factors that relate to the student, the following were listed: seven students mentioned their comfort or interest; six brought out previous background and/or familiarity with the community; two brought out that there should be an overt "issue"; and, one thought that the student should have "a basic liking for the people in the community."

One person mentioned the student should be assigned to the community and three mentioned the student should choose the community. One of the three noted that the student should be permitted to change communities if the first one was found to be inappropriate.

What was the major benefit you derived from your field experience in your selected community?

Responses to this question varied considerably and do not seem to fit into a few neat categories (does any community?). Rather than summarize the answers, a list of responses is included below which reflects the thoughts of all 19 respondents:

I gained an appreciation for the notion of 'felt needs.' I learned to see how people view their problems. Gained confidence in working with small groups. Patience.

Community assessment skills.

The stimulation of new ideas. The opportunity for development and consideration of ideas brought out in seminars.

Experiencing the power struggle—legitimizing my role.

The experience of working with clients in a setting familiar to them instead of the restricted area of the hospital.

Tolerance—and a broader base for problem-solving, problem identification, evaluation and a respect for other people's opinions and needs. I obtained a broader perspective in working with groups. More insight and security in how to get things done, e.g., timing and setting goals.

A chance to get my feet wet, try techniques. The only way to learn! Reassurance born of seeing it work. Conviction that increased competency is possible with our techniques.

The opportunity to apply new knowledge, principles as a project program based on identified needs of a community. How to write two theses—my Evaluation Committee objected to the first. Just doing a community assessment and developing statistics.

The ability to realize that individuals had different perspectives as to what are health problems, needs, etc. The many ramifications of imposing standards on a community. I learned that the consumer has a different perspective from the provider.

I felt like the experience with various agencies—hospital, public transportation, medical records—the coordination of these, i.e., how to hook them in to the needs of the community, was valuable. I'm not sure. Maybe the fact that I realized I would need to be more knowledgeable in critical areas (psychological and sociological problems of communities) to function effectively as a CNP. The concept is still an interesting one to me and I feel that I had enough of a success in seeing communities get some interest in their ability to effect changes in an area which they considered a problem. Enough of a success to see that maybe it is a very viable role.

Seeing a group obtain a particular goal by working together.

Many ways. It was broadening. I have a more general concept of what a community is. I began to see underlying cause and effect relationships.

I learned to be careful of getting the *total* community perceptions, because this dictates what will be done. I also learned to avoid preconceived ideas.

The whole concept of community organization. It enabled me to see how people can get together and make things go. It made theory more realistic.

The realization of how difficult it all is.

It seems that if there were any one theme in the above responses, it was that many of the students had their eyes opened or their horizons expanded in relation to community work. Of interest here is that this appears to have occurred with the older, experienced nurse, as well as with the newer, less experienced graduate.

What was the major benefit the community obtained from your involvement as a student CNP?

As with the responses above, these responses defy easy categorization. Therefore, they too are extracted from the students' questionnaires and notes from phone calls, and listed below.

Someone from outside to be concerned with their problems. Some initial problem-solving efforts. Successful immunization campaigns. Cleanup campaigns.

I would like to think they gain satisfaction from having a concerned individual work in the community. I feel the community sees me as a resource person for future reference.

The presence of someone they could use to add to their changing image. They didn't need *me*, just someone who could speak like a 'professional' (their quotes).

Hope and methods of organization to obtain results. They united and got some fight in them. They developed hope but were later disappointed. They were able to identify who controls [the housing project]. Rats were controlled. The group still meets.

Having a health professional work at doing some things for the community that they were asked to do, rather than coming into the community and telling the people there what they were going to do for them—the community.

Increased hope, community orientation, understanding of community needs, community-wide participation, strength in planning council (especially leadership), intergroup relations, understanding of community development by the [community action association] staff, power, a clinic.

The development of programs to protect the health of our citizens and to meet their needs as they are identified (vital statistics . . .). I was functioning as a CNP ('interested citizen') in the community prior to school and helped to develop (stimulate) Emergency Medical Services by acting as a catalyst. As a student, I developed information they could use. Since completing the program, I participated in a study of the Health Department. It was considered to be a good quality study and is a reflection of the skills I learned as a student.

I don't know if the community benefited by my involvement. Maybe an avenue to express some feelings, etc. Probably nothing. I left before any real working relationships were established with someone in the community. Therefore, the community probably gained nothing. I developed a theoretical basis, but I don't know if the information was ever transmitted to the community.

A little more direction in community action groups. The setting of priorities, directories for assistance. I understand they made some changes in the vital statistics set-up.

I hope there was some bit of feeling of involvement on their part—some confidence or encouragement to effect some kind of change. Hopefully, they feel they have a right and a responsibility to make their needs heard by the appropriate community representatives and that they were listened to and got written feedback on the questions and concerns expressed during their meeting with officials from Houston.

Encouragement and my being available to work with them, e.g., they had never thought of going to the County Commissioner and I just piled them in the car and took them.

The community didn't benefit, but it might have if I had stayed with it.

Just knowing somebody cared.

In addition, several respondents brought out that they didn't feel they had spent enough time in the community for it to have derived any benefit from their involvement. Chapter 4 discusses in some detail the outcomes in selected communities.

In what way(s) should the CNP program be modified in order to improve it?

This question was asked in terms of time, courses, fieldwork, and methods of teaching. Also, a space was left for other suggestions. Responses relating to courses and fieldwork were incorporated into earlier discussions; so this portion will primarily address the time element and the teaching methods.

Only one student said that 9 months was adequate time for the program. The remainder (19) answered in one of the following ways: 1 year, 2 years, 18 months, more than a year, more time, and 2 years would be too long. That 9 months does not seem to be enough time for the students to complete the CNP process is also confirmed by the fact that so few of the students (3 of 21) were able to complete their studies and graduate in 9 months.

Regarding methods of teaching, 5 respondents had no suggestions for change; 14 felt that there should be some changes. These suggestions may be summarized in one word: structure. Students suggested, in a variety of ways, that there was a need for more well-defined seminars and for a more structured program. Additionally, they expressed a need for role models. These needs, growing from what were probably frustrating experiences as students, are seemingly "universals"; however, in an innovative program such as the CNP program, there are no role models initially. It should be noted here that the later groups of students who did have a "practicing CNP" role model recognized the value of having such a person around.

Other suggestions touched on a number of related factors:

> More students in the program might have enriched it.
>
> The faculty is very important, . . . if the person guiding knows the role and is willing to permit students to explore. The openness of faculty is crucial towards developing a new role.

As mentioned earlier, in addition to the written questions, the graduates were asked several more general questions over the telephone. The questions, as well as summaries of the responses, are included below. Of the 19 graduates who returned the written questionnaires, 15 were reached by telephone, and it is their responses which are included.

Ten of the 15 telephoned respondents replied "No" to the question, *Do you refer to yourself as a community nurse practitioner?* four said "sometimes" or "occasionally," one replied "yes." Reasons stated for not using the title were: "no one knows what it is," "it has too many clinician connotations," "it became confusing to people," "they assumed I had physical assessment skills," "no document (certificate, diploma) was issued to us to support our claim," "too much trouble trying to describe what it is," and "I am not working in that capacity at present."

Looking back over all, how do you view your experience in the CNP program? Of the 15 telephoned respondents, 9 (60 percent,) described their experience in the program as positive, 3 (20 percent) were ambivalent or neutral, and 3 (20 percent) described it as negative. Factors that were mentioned as contributing to positive feelings were: the open and relaxed presentation of the program, learning about community development and organization, the support of others in group meetings, breaking down "blinders" concerning the traditional role of the nurse, a chance to be creative, input of the staff (faculty), and the opportunity to read. Factors mentioned as contributing to negative or ambivalent feelings were: poor communications between the student and staff, student's inability to relate theory to practice, excessive pressure to accomplish something in the community totally by oneself, difficulties experienced with the student's Evaluation Committee regarding master's project, conflict within the student group and between the student group and faculty, and too much expected in too little time.

What are the weakest and strongest parts of the CNP program and faculty?

Comments pertaining to weaknesses of the program and faculty seemed to emanate from the generally perceived unstructuredness of the program. That is, a graduate mentioned that "no one could define CNP," and another that the program was "vague." Also mentioned was that "realistic implementation was lacking." Other comments seem to be similar to criticisms of most graduate programs, such as, "too much material in too short a time," and "all seminars were not meaningful."

Of interest in the comments about the "strongest" part of the program is that the same areas designated as "weakest" were also listed as strongest. For example, "flexibility," "freedom," and "open, relaxed presentation." Additional comments are listed below:

> For me, the newness of the concept. You weren't already programmed into a role model.
>
> The careful and lucid outline of goals for the year.[3]
>
> The idea or concept of the program itself is its strongest feature. The objectives seem relevant to this.

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[3] This was not written by student in the first year.

It helped me see nursing in an expanded role, i.e, how to function other than clinically.

It focused the M.P.H. It was a very broadening program. The M.P.H. was kind of like a smorgasbord at first and the CNP gave it a handle.

Positive comments about the fieldwork experience also mentioned "freedom" and "liberty to form a plan of operations" One graduate stated, "Being able to select your own community and being able to do your own thing. This only works, however, with certain types of people, and students selected for the program should be able to function in unstructured settings."

The graduates' perceptions of the faculty similarly reflect some ambivalence. Negative comments relate to "inconsistency between instructors in assignments" a "preoccupation with problem-oriented records" (this comment could not have come from someone in the first or fourth years since little on this subject was covered then), and being "unrealistic about what could be done in a community." On the positive side, several graduates specifically singled out the "support" received from the CNP staff. Other comments included the positive effect of having a CNP graduate contribute to the seminars and the "commitment of the staff."

Do you utilize aspects of the CNP program in your work situation?

Fourteen graduates answered this question. Three answered "no" and 11 or 79 percent answered "yes." Aspects singled out for mentioning by the graduates fell primarily into two broad categories: those related to assessment and those related to planning. Specifically, they brought out the following (not all comments are included):

assessment and observation skills
making contacts with agencies
more confidence in approaching people
promotion of windshield survey
can find resources immediately
defining problems and proposing solutions
dynamics of communities
community identification (boundaries for planning)
principles of community development and organization.

Along with the above question, graduates were asked about their present jobs. Of the 17 responding, the 3 who said they do not utilize CNP concepts are working as: (1) instructor at a college of nursing, (2) a coordinator of a State tuberculosis program, and (3) a State nursing home consultant. Positions listed by the remaining CNPs who related that they do use CNP concepts included the following:

Director, Family Planning Services, College of Medicine
Community Health Program Coordinator, County Health Department
School Nurse (2)
Clinical Liaison, School of Nursing (liaison with community agencies)
Supervisor, City/County Health Department
Nurse Coordinator, Neighborhood Center
Chief of Nursing Service, City/County Health Department
Community Nurse Practitioner (2), City Health Department, CNP Project

The last question asked of the graduates was, *How do you define a community nurse practitioner?* Following are their definitions or excerpts from their responses:

> A public health nurse in a broader sense.
>
> A person with expertise in working with community groups.
>
> A non-nurse attitude—an expanded awareness of what nurses can do in a community other than give injections.
>
> A person who works with problems of groups of people. Helps groups research different ways of solving problems. Helps make contacts to particular people who can effect change.
>
> An individual who looks at the community as a whole . . . assesses needs as defined by the community . . . identifies strengths and weaknesses and develops programs.
>
> A crackerjack public health nurse.
>
> A nurse practitioner in advanced practice who does assessment, problem identification, and has skill in planning and evaluation specific to an area or community and focused on a group.
>
> Working within a community as a whole, carrying out the nursing process.
>
> A person with the ability to deal with the total spectrum of health needs in a community. A catalyst and resource person rather than a 'doer.'

Of note in the above statements is that the same key concepts discussed as essential earlier in this report (chapter 2) are also brought out by the graduates; that is, focusing on groups rather than individuals, applying nursing process to the community as a whole, helping communities to help themselves, and being open to dealing with any community-defined problem.

Chapter 3

COMMUNITY OUTCOME ANALYSIS

Just as all life is constantly changing and producing new forms, so too, communities, with a life of their own, are constantly changing. At times, life, whether of an organism or a community, is strong enough to overcome whatever obstacles lie in its path; at other times, external or internal factors, compounding the weakness and fragility present, prove too much for the organism or the community. Reflecting such a dynamic, the 21 communities in which CNP students worked during the past 4 years demonstrate both signs of growth and decline.

Health Needs

In reviewing and evaluating the efforts of CNP students in various Houston area communities, an understanding of the concept of process is helpful. Ideally, an initial determination of each community's "life" should have been obtained as an important baseline against which to measure future changes in each community's health *status*, its community health *capabilities*, and its community action *potentials*. In reality, however, the developmental nature of the CNP project, as well as the learning process underway within each student, made it difficult, if not impossible, to obtain similar baseline information for each of the 21 communities in which CNP students worked.

The completeness of each community assessment varies considerably and is dependent not only on the individual student's abilities and commitment to the CNP role, but also on the progress made by the CNP staff in developing guidelines for the student's community involvement. Even though obvious deficiencies in the health needs assessment of the various communities exist, the CNP Project is fortunate in being able to compare several of the students' assessments, developed through a combination of participant-observation and standard secondary date sources, with recent assessment of the same areas completed by the City of Houston. Since the great majority of the CNP students was involved in communities defined by the city in 1975 as "Community Development Planning Districts," current assessments of these areas are available. Although three technical groups—a Management Improvement Task Force, a Citizen Participation Task Force, and a Housing Assistance and Technical Advisory Group—participated in the assessments conducted by the mayor's office, comparisons of the two groups of assessments—those completed by the city, utilizing the extensive resources of the mayor's office, and those by the CNP students—frequently show striking similarities.

However imperfect the students' assessments, they clearly demonstrate how community health nurses who possess the requisite skills can—with limited resources of time and energy—identify not only a community's needs, but also indicate those needs considered of highest priority by the community residents themselves. The implications of this finding for community health nursing practice should be evident.

All seven CNP students who worked in the five areas selected as "Year I" priority areas by the City of Houston's Housing and Community Development Division identified community needs similar to those identified by the various Task Forces—needs arising from deficiencies in either the physical or social and behavioral environment. Supportive services, those related to the needs of the communities for day care, recreation, services for the elderly, protection from crime, legal services, and transportation, were given high priority. Surprisingly, in both the students' and the city's assessments, the need for citizen involvement and neighborhood organization ranked, in all the areas, among the top four priorities. The need for health services, especially among young or elderly populations, ranked high in the various assessments, but as noted by others throughout the country, health services, although routinely ranking high in a community's list of priorities, rarely receives top priority.

In those sections of the city selected as "Year II and III" priority areas, and in which eight CNP students had their fieldwork experiences, community members identified needs and priorities similar to those mentioned above. Almost without exception, environmental hazards—abandoned housing, trash, inadequate drainage, etc.—caused community residents considerable concern over the unhealthy state of their neighborhoods. While the inaccessibility of several of the communities compounded the seriousness of their situations, their low economic levels and limited "control" over the life of their communities appeared to exacerbate all the problems identified.

Two other CNP students who worked within Houston's city limits became involved with communities or subgroupings living in housing projects, one of which was operated by the City of Houston Housing Authority and the other established by the Catholic Diocese of Galveston-Houston and the Episcopal Diocese of Texas and governed by the Houston Metropolitan Ministries through a Board of Directors, a Project Director and a Residents' Council. Housing projects such as these, in which the Department of Housing and Urban Development subsidizes large percentages of the residents' rents, are most attractive to young adults with growing families and the elderly who, living on fixed incomes, have increasing difficulty keeping pace with the national rate of inflation. In such settings, problems of the elderly, as well as those of busy young mothers with several small children under the age of 5 years, became quickly apparent. In addition, the peculiar obesity produced by living on food purchased with food stamps was readily evident. When the residents were asked by CNP students, however, as to their needs within the housing projects, problems of the physical and social environments received the highest priority. Problems most frequently identified were the excessive number of rats, poor drainage, delinquency, alcoholism, and inadequate public transportation, not to mention apathy on the part of the residents themselves and indifference on the part of elected officials. Once again, the delivery of personal health services did not appear high on the list of residents' priorities.

In two nonpoverty areas in which CNP students were involved—areas consisting of relatively homogeneous groups of professionals, skilled technicians, managerial and supervisory personnel—common health problems took such forms as hypertension, cardiovascular disease, cancer, and obesity—all dysfunctions believed to be related to the civilized, highly technological society in which the residents lived and worked.

In areas outlying the city, CNP students found all of the abovementioned problems, especially those relating to the physical environment, compounded by the frustrations of community groups who had to deal either with overlying governmental jurisdictions or rural and semirural county governments unable to provide the multitude of physical and social services required by their inhabitants. Two CNPs worked in communities bisected by the City of Houston and Harris County. One student, at work in a distant Harris County community, was faced with massive environmental problems, while others, including a non-CNP student supervised by Project staff, at work in Polk, Fort Bend, and Walker Counties faced problems principally related to implementing the planning process in communities with limited resources.

Community Change

If an understanding of "process" was essential when looking at the various community assessments attempted by CNP students, it is even more essential for an understanding of the "changes" that have occurred in these same communities during the past 4 years. One needs only a casual perusal of current health-related journals or texts to discover numerous articles attesting to modern society's difficulties in altering—to any significant degree—its health status. In addition, for reasons commonly known to qualified health professionals, indicators such as mortality rates, life expectancy, and infant mortality data rarely are readily available at short-term intervals. Even if such data were currently available to the CNP Project staff, it is inconceivable that traditional health status indicators such as these, which have remained relatively unchanged during past years—in spite of massive expenditures of professional energy, time, and financial resources—should be used to measure the impact of CNP students on the health of communities. Student CNPs, working in communities an average of 8 hours weekly should not be expected to influence such relatively unchanging rates.

One of the CNP Project's long-range goals was from the beginning to improve the general health of communities; objectives leading toward this goal were frequently phrased in terms of improving a community's ability to work constructively toward the alleviation or resolution of its health-related problems.

Acting on the assumption that activities directed toward the development of a community's competency would ultimately affect its general health status, CNP staff often encouraged students to set "process" goals related to this competency, as well as to the achievement of specific program outcomes.

Since such process goals are, of their very nature, imprecise, community work administrators and practitioners have struggled over the years to quantify health-related community development "successes" and "failures." Highly visible undertakings, such as clinics built, personnel prepared, patient visits, etc., are relatively easy to enumerate, but it is becoming increasingly evident that such figures may, in reality, tell us little about a community's health. Although recent efforts in the study of social indicators give considerable promise in this regard, the CNP staff during the past 4 years joined the ranks of those struggling to develop indicators for a community's developing abilities.

Such indicators should, of course, be routinely included in all baseline community assessments undertaken by community health workers. Had CNP staff and students been able to include such indicators from the first years of the Project, it would, theoretically, be possible to compare them with current assessments of these same communities. It is hoped such comparisons would provide evidence of change and would assist in the search for progress attributable to the work of CNP students. Although the developmental nature of the CNP Project makes such comparisons impossible, it is the staff's present opinion and strong recommendation that a limited number of indicators be included in all assessments of any future CNP projects's efforts and routinely monitored over time.

These indicators, relating to the competence level of a community, have been developed both on the basis of the Project's 4 years of experience in a diversity of community settings, as well as on the reflections of Leonard S. Cottrell, Jr. of the University of North Carolina at Chapel Hill. In a chapter entitled "The Competent Community," written for inclusion in a book scheduled for publication in 1974, but not yet published, Cottrell points out that a competent community's various component parts:

1. are able to collaborate effectively in identifying the problems and needs of the community;
2. can achieve a working consensus on goals and priorities;
3. can agree on ways and means to implement the agreed upon goals;
4. can collaborate effectively in the required actions.[1]

It is his opinion, therefore, that in order to function completely, certain necessary conditions or specific capabilities must be present or developed within a given community. Theoretically, once again, measures of change in these variables could well provide an index of the community's overall competence. The word theoretically is used because Cottrell does not indicate that measurement of these variables has been systematically undertaken, nor is the CNP staff aware of settings in which this has been attempted. In Cottrell's provocative chapter, he suggests the study of eight variables, fully aware that these same variables are frequently overlapping and even, at times, reciprocal. They are:

1. *Commitment* to the community by its members who see themselves in a valued relationship that has a vital impact on their lives, and in which they have a significant role. Involvement is seen as strengthening commitment to the collective life of the community. Should the roles played by different commu-

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[1] Cottrell, Leonard S., Jr. "The Competent Community." To be published in: *New Explorations in Social Psychiatry.* Alexander H. Leighton, Berton Kaplan and Robert Wilson, Eds. Basic Books.

nity members, however, have little impact on the community processes, their activity becomes meaningless.

2. *Self-other awareness and a clarity of situational definitions* refers to the clarity with which each part of the community perceives its own identity and position on issues within the community context, as well as the relation of its position to that of the other components.
3. *Articulateness* refers to the ability of each community segment to articulate its views, attitudes, needs, and intentions plus its ability to articulate its perception of its position *in relation* to that of other community segments. It is, of course, reciprocally influential with the community's awareness.
4. *Effectiveness of communication* indicates the ability of the various community components to listen, to hear what each is saying and, when taking the role of the other, to see the situation accurately from his position.
5. *Conflict containment and accommodation* refers to the repertoire available to community components by means of which they are able to accommodate conflicts while, at the same time, working toward a resolution of the sources of conflict.
6. *Participation* refers to the ongoing commitment of community members to define community-wide goals, and prescribing the manner in which they are to be implemented and enjoyed.
7. *Management of the community's relations with the larger society* is essential if it is to utilize those resources and supports which the larger social system makes possible.
8. A community's *machinery for facilitating participant interaction and decision-making* refers to those *means* by which it interacts with its own component parts and with the larger society.

Since Cottrell suggested using the above categories as tentative criteria by which to measure a community's progress toward improved competence, a CNP staff member developed a short series of open-ended questions relating to a combination of these variables and attempted to use them as the framework upon which to base her recent discussions in some of the communities where CNP students had been involved. This was done with the dual purpose of ascertaining, to the degree possible, changes in the respective communities which might be attributable to the work of CNP students, as well as an initial testing of usefulness of Cottrell's variables in such an undertaking. Those variables selected for use and the questions deemed helpful in eliciting information about the different categories, were:

Community—Commitment:

Name of community or community group?
Name of person being interviewed?
Relationship of person being interviewed to community (affiliation, perspective, frame of reference)?
Role played in the community by person being interviewed—

  Component or segment of community with which interviewee is identified?
  Period of time in which role was played? at what level?
  Voluntary or salaried? by whom?

Self-Other Awareness/Clarity of Situational Definitions:

What are major interests and goals of specific component or segment of community with which interviewee is identified—

  At the present time?
  At the time a CNP was involved in the community?
  (Look for specificity especially as to *positions* taken by the community in relation to their interests and those of others, as well as some indication of an *awareness* of what implications follow from these positions.)

What are—

  Differences in interests with other segments of community?
  Similarities in interests with other segments of community?
  Conflicting interests?
  (Note evidence of *respect* and *understanding* of other positions.)

Participation (emphasize development of participation in existing or developing organizations:

Identify specific instances in which segments (which ones) of the community were involved with:

  Definition of community goals.
  Manner of achieving community goals.

How (in some detail) were the segments involved?
Who profitted from the achievement of the goals? enjoyed the results?
How effective were the *results* in terms of amount of *effort* involved in achieving the community's participation?

Machinery for Facilitating Participants' Interaction and Decision-Making:

Identify specific *mechanisms* for interaction and decision-making:

  At the present time.
  At the time a CNP was involved in the community.

From a personal viewpoint (person being interviewed), how do these mechanisms provide for:

Breadth of representation?
Rotating involvement in decision-making?

What is the relationship of *actual* implementation to decisions taken?

Management of Relations with Larger Society:

From a personal viewpoint (person being interviewed), what is the *radius* of relationships of the community/segment with other communities/segments?
What are the positive effects of these relationships on the community?
What are the negative effects (or constraints) placed on the community/segment by these relationships?

Problem-Solving:

What are the major problems facing your community/segment today?
Are they the same or different from those at time of CNP involvement?

If same, are conditions worse, better, or just the same in your community today? why?
Who is mainly responsible for the problems being better-worse, or just the same?

In initiating discussions with community members, the CNP staff member identified herself as a faculty person from the University of Texas School of Public Health who had become interested in the community through a previous student who had worked in the community. No attempt was made to identify the student by name and the discussion was carried on in a most informal manner with no attempt to take formal notes. Community members were always assured that they would not be publicly identified in any way.

Communities were selected for visits by CNP staff principally on the basis of the amount of time a CNP student or graduate had remained in the specific community. Since only four of the CNP students who had participated in the entire sequence of CNP courses remained longer than 12 months in a given community, all four communities in which these students had worked were visited by a staff person. Plans were also made to visit two of the four communities in which the latest group of CNP students was involved. Although students and faculty alike continually emphasized the limited results that might be expected in a short 9-month period, these two communities were selected because of the previous nursing experience and self-directedness of the two students who worked in them. In addition, one had already received her M.P.H. with the Project) and the other expected to receive her degree shortly. Although circumstances did not permit the revisiting of more than one of the 1975–76 communities, the numerous discussions held in the other communities visited were sufficient to indicate clearly the utility of Cottrell's variables in monitoring a community's growth toward "competence."

Analysis of the various discussions held in each of the communities reveals some interesting, but not surprising, phenomena. In one of the communities where a CNP had worked for a period of approximately 18 months, both as a student and as a graduate, considerable evidence exists today of her presence there almost 4 years ago. The community center which she had played a part in establishing is still functioning; the Senior Citizens' Nutrition Program, providing not only hot meals but also opportunities for socialization, is serving from 60 to 85 meals daily, and the residential facility, established as an alternative to detention for adolescent women, is apparently still meeting one of the community's needs. However, while earlier attempts to provide recreational programs for elementary school-age children has finally become accepted in the community, the sole counseling service in the area is only partially functioning and the Crisis Help-Line has been discontinued due to the difficulty of retaining volunteers. None of the founding members of the community corporation, nor the first executive director, is currently involved with the community center, but it may be assumed that this is due as much to the high mobility of the area's residents as it is to a lack of interest. Given a new needs assessment of the area, plus renewed attention to the community's involvement and participation in the center, and emphasizing the development of local community leadership, there is reason to believe that the community center could become an increasingly vital part of the community.

In another much smaller community where a CNP had worked for approximately 18 months, a considerable amount of hostility appears to exist between the members of a once dynamic civic club. As happens in many communities of this size where the relatively few residents continually interact with one another, rival factions appear to be well on their way to destroying the accomplishments brought about by the hard work of the community. Whether or not the presence of a community nurse practitioner (or a person in a similar role) would have been able to prevent the current state of inaction and open hostility in the community is open to conjecture, but, during the time in which a CNP was actively working with the community, she was able on several occasions to act as a buffer, helping to direct the community's energies toward activities beneficial to the community as a whole.

One other important feature should not be ignored and that is the eventual weariness that comes to such communities as they continually face severe community problems. Surrounded by long-standing environmental problems which they are incapable of resolving, community members should not be judged too severely for adapting to the harsh reality of their situation. In the small community described above, crisis brought the group together several years ago. As one community member expressed it, "A flood made us work together; maybe what we need is another flood."

In the community in which a CNP student worked for approximately 15 months as a student and as an employee of the City of Houston Health Department, no trace remains of the Parents and Youth Center with which the student had been involved, however reluctantly. The student's doubts as to the legitimacy of the director's intentions, as well as the actual involvement of community residents in the Center, appear to have been well justified. However, in the larger community where the student worked, the multipurpose center he was associated with is well known and utilized in the community. In addition, several of the community residents have continued their efforts to establish a grassroots umbrella-type community organization that has an active health and safety committee. Although there is no specific connection between the establishment of such an organization and the presence of a CNP in the community, it should be assumed that, had the student remained in the community, he would have shared his professional community health expertise with such a group. One very indirect indicator of the effectiveness of this CNP's contacts within the community was the desire of his employers within the Health Department to either hire another CNP or keep the position open as long as possible, in the hope that it would be possible to rehire him. Once again, the student's mobility was the deciding factor.

In the community in which a CNP has been working for the past 18 months, it is possible to identify numerous community strengths related to the increased enthusiasm and participation of community members in the life of the community. A mixed group has become relatively active in directing the affairs of a reactivated Civic Club and efforts are being made to relate to several of the City of Houston's departments, including the desire to coordinate the removal of abandoned housing with similar activities of the new Community Development Division. Fragile, at best, the community's new-found enthusiasm is in danger of the same pitfalls that befell the above-mentioned small community. If, however, serious attempts are made to strengthen the participation of a broad spectrum of community members, thus indirectly limiting the dominant roles played by only one or two, it is possible that a new life of its own may be developed in this little community. A realistic assessment of the possible gains to be achieved from the City of Houston, as well as the time necessary to achieve them, should also be a factor in developing a constructive versus antagonistic relationship with the various departments within the city government.

The most positive of all the community visits was, perhaps, the one to a small Mexican American community, in which a CNP is now working. Beset with massive physical and environmental problems and consisting, it is suspected, of numbers of illegal aliens without access to health care services, it has rallied to join forces with the CNP in establishing a weekly nursing clinic. Community residents are responsible for much of the functioning of the little clinic and the possibilities for the future appear endless. Functioning in collaboration with one of the CNP graduates who is now employed by the County Health Department, the CNP has vividly demonstrated the validity of the CNP approach in mobilizing community residents in the resolution of their health problems.

The breadth of the Project's experiences, not only in the above-mentioned communities, but in all of those in which community nurse practitioners have been involved, is consistent with the Division of Nursing's expectations relative to the demonstration of an evolving role for nurses working in the community. One of the principal functions of a demonstration project is to explore, take risks, even stumble. However, in this very stumbling are to be found new insights and directions. In this respect, the CNP students, graduates, and staff have indeed been risk-takers. At times the price has been high, but well worth the effort, for it is the opinion of the CNP staff that, in spite of what appears to be a limited impact of CNP students on the health of their communities, sufficient data have been acquired to justify the further development of the CNP role. New self-correcting efforts, building on the experiences of the CNP demonstration, but emphasizing the intervention and evaluation phases of the CNP process, should, in time demonstrate the role's measurable impact on community health.

Chapter 4

DEVELOPMENT OF A COMMUNITY-ORIENTED HEALTH RECORD

Introduction

"The enormous number of variables that exist and the lack of structure and control in the community demand of a nurse a high degree of knowledge and skill. . .(*1*)."[1] Ms. Knight might well have added that keeping accurate and usable records demands inordinate patience, stamina, and an encyclopedic memory. The record-keeping system for the Community Nurse Practitioner Project is next addresed; first, a short description of the development of the system; then a thorough discussion of what has evolved to this point; and last, some examples of the most recent records.

One of the earliest concerns expressed by the CNP staff was for some kind of method to organize the enormous amount of information which would emanate from the CNP's involvement with the community. Could this information be kept in such a way to facilitate evaluation at a later date? How would the student demonstrate what she was doing in the community? And, how she arrived there? And where she was going?

The sociologists' standby, field notes, seemed a logical place to begin. We did not want to limit the input by handing the student a list of categories or areas to cover but wished to allow each to write all that she could about each encounter. Additionally, the student was exposed early to biometry and epidemiology and was encouraged to include the more traditionally used health indicators, such as mortality and morbidity rates. These, too, were to become part of the record.

This early record was termed a "diary," and quite readily some students had large notebooks spilling over with data about their communities. By the second semester of the first year, students and staff recognized the need for a more structured, but still flexible, system of keeping records of community work.

Lawrence Weed of problem-oriented record fame had spoken at a local gathering which several of the staff members attended early in the year. His logical and straightforward approach became a topic of discussion with the students. Students and staff agreed that adapting Weed's system to the community might be a viable direction to take, and one student in particular devoted a great deal of time and effort to this task. A summary of the chapter in her master's project describing this development follows(*2*).

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[1] Italic numbers in parentheses refer to literature cited in list at end of chapter.

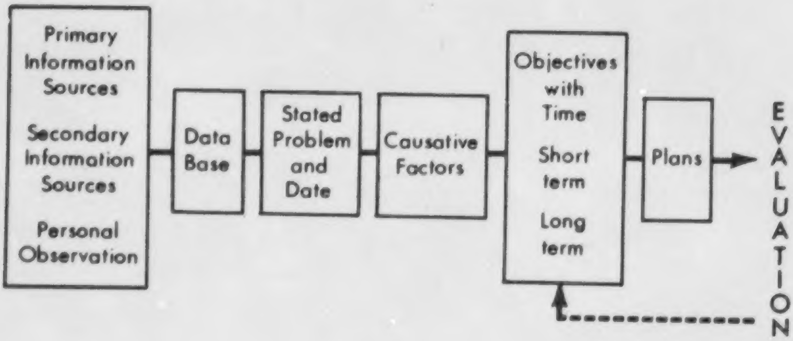
Problem-Oriented Community Record

Initially, a "problem analagram" (coined by the student to mean a problem analysis diagram) is developed for each problem encountered in the community. The analagram (figure 8) is comprised of five basic elements:

1. a defined data base
2. stated problem
3. causative factors
4. long- and short-term objectives
5. initial plans.

This analagram becomes part of the problem-oriented community record P-OCR) which is made up of three components: a complete list of community problems, an analagram for each problem, and progress notes. The progress notes use the format NAP (narrative, assessment, and plan) rather than Weed's "SOAP," since the narrative and assessment include both the objective findings and the subjective impressions of the CNP.

Figure 8.—The problem-oriented community record, problem analagram


Primary Information Sources
Secondary Information Sources
Personal Observation
Data Base
Stated Problem and Date
Causative Factors
Objectives with Time
Short term
Long term
Plans
EVALUATION

At the start of the following year, with a new group of students, staff attempted to introduce the concepts of the P-OCR early in the curriculum. A videotape of Lawrence Weed describing his system was shown during a preschool workshop for the nurses. Several hours were devoted to discussing the need for such a system and how it had been used to that point. A rather extensive bibliography was also furnished.

Not surprisingly, students balked at the need for record keeping in the community and brought up the need for a more "positive" approach to the community. Such topics as building the record-keeping system around "problems" became issues with which the group, both students and staff, grappled. "But, what if something isn't really a 'problem,' but is potentially a problem," some students asked, "then where does it go?" Also, one student was concerned with, "What should I do with my personal goals in that community?"

Community-Oriented Health Record

These and other concerns brought us to a community-oriented health record. As one student described the C-OHR, it is both a tool and a concept (*3*). As a tool it is a systematic way of recording activities in the community, and as a concept, a way of looking at the community with an emphasis on strengths and health rather than problems and disease.

As it evolved, the C-OHR consisted of four parts: a data base, list of problems or objectives, plans, and progress notes. Information for the data base of the C-OHR, used to formulate problems and objectives and as the basis for all activity, was seen as analogous to the patient record (*4*). This is summarized below:

Patient Record	Community Record
Chief complaint	What the people say
Profile and related social data	Community Profile and demographic data
Present illness	Problems inferred
Systems review	Larger systems—social, economic, political, etc.
Physical exam	"Windshield" survey
Lab work	Vital statistics, epidemiological studies
Past history	Past history including legislation, etc.

Recent students and graduates have been faced with particular challenges in developing and adapting the community-oriented health record to their community practice. They were able to accept the principles of the record that had been developed by students and project staff ealier in the program, but they desired to further develop the record into a workable tool for community practice. A need was expressed to have and use a record that would structure and monitor, as well as reflect, one's community practice. Such a record could also be useful in teaching the core of behaviors necessary to the community nurse practitioner's practice. In addition, the record would need to provide for continuity in the community—a need discovered by recent students affiliated with local health agencies.

In view of the above concerns, it seemed necessary to develop a set of forms which would facilitate the structuring and recording of each phase of the community nurse practitioner process, i.e., community assessment, problem identification, planning, intervention, and evaluation. Following is a discussion of each of these areas and recent developments of a record that attempts to incorporate each phase of the process. Examples of the forms that are being tested are also presented.

Assessment

The record must facilitate a systematic assessment of the health of the community in order for the CNP to identify and analyze the community's health problems. The record should aid the CNP in discovering pertinent information about the community, recording it, and retrieving it for use in problem-solving efforts.

In order to discover pertinent data about the community, the practitioner should be guided by the record to use the most complete approach to the community that is available. Attempts have been made to formulate and specify categories for assessment that reflect such a holistic approach. Following is an outline of the assessment categories that are currently being tested (*5*). Subcategories may vary depending on the community. In parentheses are some possible subcategories.

PHYSICAL ENVIRONMENT

- Land use—may be mapped
  - Open spaces
  - Undeveloped space

- Residential space
  - Single family housing
  - Multiple family housing
  - Settlement patterns
- Commercial space
  - Private (taxable—stores, etc.)
  - Public (nontaxable—schools, etc.)
- Industrial space
- Water covered
- Roads
- Boundaries (geographic, social, and political)
- Agriculture, animal husbandry

Environmental status
- Sanitation (debris, vectors, waste disposal, water drainage)
- Air
- Utilities (water, gas, phone)
- Household pets

Topography and geology

Flora and fauna

SOCIAL AND BEHAVIORAL
- Education
- Religion
- Recreation and entertainment
- Health (may develop many subcategories under each number)
  - Services (clinics, hospitals, physicians, etc.)
  - Practices (nutrition, childbearing)
  - Status (positive and negative indicators)
  - Theory of disease causation, lay diagnosis, and treatment (herbal remedies, folkhealers
- Family living patterns, standards, and routines
  - Infancy
  - Childhood
  - Adolescence
  - Adulthood
  - Old age
- Population
  - Demographic variables (age, sex, race, etc.)
  - Groups and interpersonal relationships
  - Associations
    - Special interest
    - Planning
- Communications
  - Public (radio, T.V., newspaper)
  - Private (informal links such as gossip)
- Transportation and travel

ECONOMY

Economic status (credit, ownership data, tax base)
Labor (employment, labor organization, wages)
Finance (banking, savings practices, etc.)
Property (ownership, acquisition practices)

GOVERNMENT

Districts (consider all resources such as police protection, welfare, etc.)
Representatives

As can be seen from the above outline, the assessment categories are broad in order to guide the practitioner to view the community in as complete a manner as possible. Some areas of community life may be of more concern than others in the health assessment. This would suggest that the CNP assess those categories more fully, developing pertinent subcategories. Where feasible each community to be assessed is viewed according to Connor's defined elements of the "social compass (*6*)." These elements are:

History
Space relations
Resources
Technology
Knowledge and beliefs
Values and sentiments
Goals and felt needs
Norms
Power, leadership, and influence
Social rank
Sanctions
Positions and roles

Many of these elements are particularly applicable to assessing the social and behavioral categories.

The assessment record must aid the CNP to record and use the community data, as well as to discover it. Early CNPs recorded their observations, interviews, etc. in diary form. The information was later analyzed to produce a community profile. Because the community is constantly changing, and because the CNP is continually discovering new information about the community, it became necessary to develop a system of recording and holding the community data base. A description of one such system follows:

Community data are recorded on a Descriptive Data Recording Form, figure 9. This form permits the CNP to specify the assessment category and subcategory for the data. Each entry on the form includes the source of the information, reliability (recorder's assessment of source of the information), date, and the name of the recorder. To standardize the recording, a rubber stamp containing these information categories is used.

All of the descriptive data are filed in a large notebook which is divided and indexed according to major categories and subcategories. A list of all these categories is contained in a plastic cover in the front of the notebook. This serves as an index to what information is recorded. Pocket fillers are included in the notebook to hold blank Descriptive Data Recording Forms and any up-to-date analysis of the community data.

Because a notebook filing system can expand to accomodate increasing information about the community, and because it can be made easily accessible to other community workers for their input as well, it is satisfactory as a means of holding the community data base.

In summary, regardless of the exact form that a data base record takes, it should fulfill definite criteria in order to facilitate and structure assessment. It should:

- be able to accept any and all community descriptive data no matter how insignificant they may seem;
- be open to new data reflecting change in the community;
- make information available for verification and validation;
- allow for description of source and quality of data;
- be available for study by any public health worker who may analyze the data from a different perspective;
- allow for the expansion of information in problem areas without destroying the holistic approach to community;
- allow for the same community data to be used in the study of any number of community problems;
- allow for contributions from other public health workers according to their specialties;
- be applicable to any size community, as long as boundaries are firm;
- allow for cross referencing during analysis;
- be inexpensive and require minimal effort to use;
- be usable by an agency serving the community;
- separate analysis from data recording (*7*).

Problem Identification

Once the pertinent community data are collected and recorded they can be analyzed to determine community health problems. A problem list, which makes up the base of the problem-oriented community record, can be compiled. Each problem on the list can be documented by data already recorded, and a notation as to where the supporting data may be found in the data base is made next to the problem on the problem list. In this way there is a link between the data base and the problem list. Each problem should be numbered so that the CNP can relate planning and intervention efforts to it. The date that the problem was identified, as well as the date resolved, should be included.

A form may be used to standardize the information needed on the problem list. An example of a suggested form for a community problem list is included here as figure 10. An example entry on the form is illustrated.

Planning

The record should also facilitate the CNP's planning to intervene in community problems. This is done by providing a recording structure for each of the steps in the planning process, that is, specifying goals and objectives, analyzing a problem for causes and effects, inferring intervention points, and planning activities to intervene.

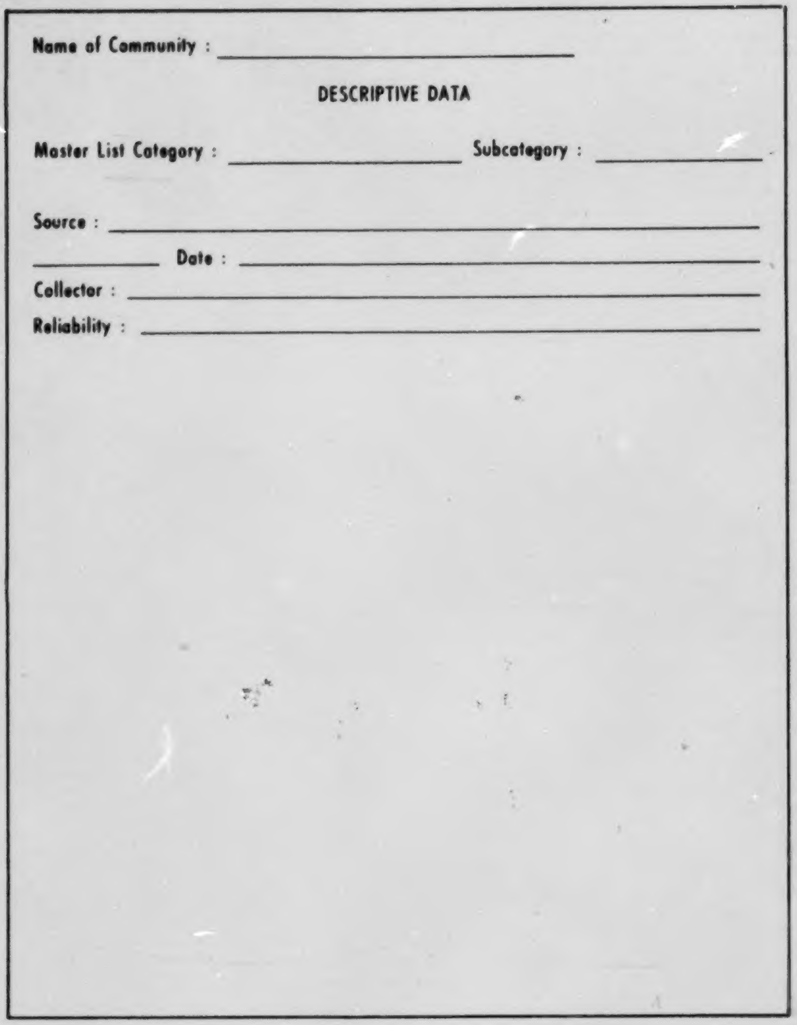
Specifying Goals and Objectives

Planning starts with specifying one's goals or exactly what outcome is desired. In order to be able to later evaluate progress toward a goal, it becomes necessary to specify precisely the exact outcome desired in a certain period of time. Figure 11 illustrates a goal planning form designed to facilitate evaluation as well as planning. An example of a planning entry is shown.

Problem Analysis

The community nurse practitioner faced with a list of numerous community problems responds in a fashion similar to that of the physician in response to his patients' problems. Some problems require immediate therapy and others need to be analyzed further to make a diagnosis. With regard to an ill patient the steps toward diagnosis (lab, X-ray, etc.) are fairly well defined. The steps for determining the root causes of the problems of a community are not so well defined. Blum suggests analyzing a community problem according to its tertiary, secondary, and direct precursors, as well as its direct, secondary, and tertiary consequences (*8*). The links be-

Figure 9.—Descriptive data recording form with rubber stamp impression



Name of Community : ____________________

DESCRIPTIVE DATA

Master List Category : ______________ **Subcategory :** __________

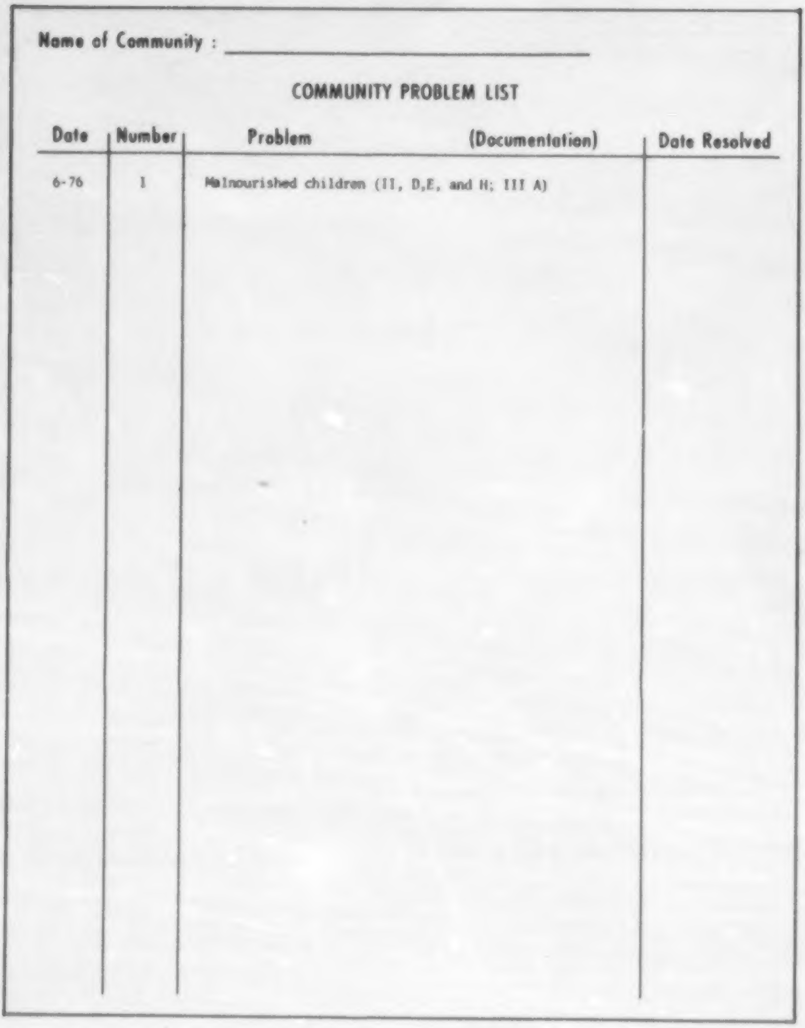
Source : ______________________________

____________ **Date :** ______________________

Collector : ____________________________

Reliability : ___________________________

Figure 10.—Community problem list form with example entry



Name of Community : ____________________

COMMUNITY PROBLEM LIST

Date	Number	Problem (Documentation)	Date Resolved
6-76	I	Malnourished children (II, D,E, and H; III A)	

Figure 11.—Goal planning form with example entry

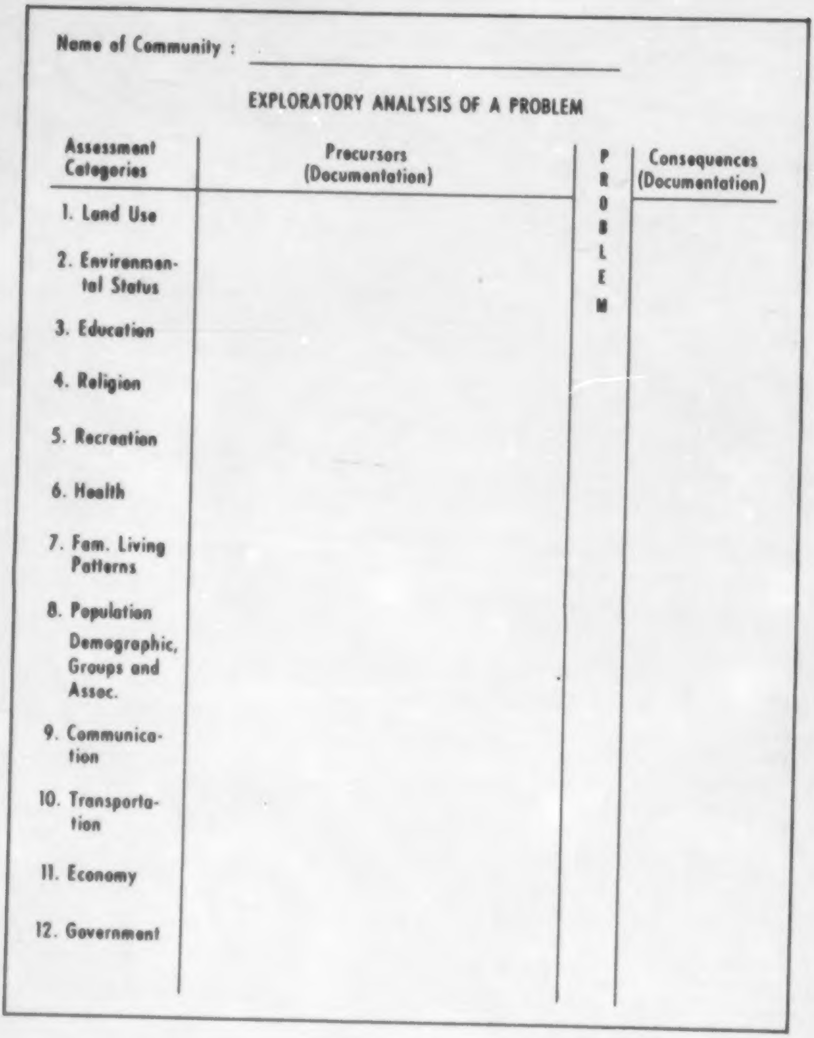
Name of Community : ______________________

Problem/Goal No. 1

Goal Statement : Well nourished children by 1980

Date	Objectives (Measurable Desired Outcomes)	by date :
7/76	#1 50% of all infants under 1 yr. to be properly nourished by 1/77 as evidenced by developmental and hematocrit testing of all infants seen in all clinics.	1/77

Figure 12.—Problem analysis form



Name of Community : ______________________

EXPLORATORY ANALYSIS OF A PROBLEM

Assessment Categories	Precursors (Documentation)	PROBLEM	Consequences (Documentation)
1. Land Use			
2. Environmental Status			
3. Education			
4. Religion			
5. Recreation			
6. Health			
7. Fam. Living Patterns			
8. Population Demographic, Groups and Assoc.			
9. Communication			
10. Transportation			
11. Economy			
12. Government			

tween the precursors, the problem, and the consequences delineate possible intervention points.

CNP students have recognized the value of analyzing community problems according to their precursors and consequences, but have found Blum's model somewhat complicated. In an effort to simplify Blum's model, to integrate the problem analysis with the community data base, and to permit inclusion of the problem analysis into the community-oriented health record, the Problem Analysis Form, as illustrated in figure 12, was developed. The listing of the assessment categories on this form is done to encourage the CNP to look for problem precursors in all factors relating to community life in order to discover the multitude of possible intervention points that exist.

Inferences for Nursing Intervention

The CNP, having analyzed a community problem, will plan to intervene at what appear to be the most advantageous intervention points, based on available data and the CNP's knowledge of the community's needs, goals, resources and constraints. To provide for continuity of intervention in the community, the community record should reflect the personal choices of the CNP and community factors that precipitated an intervention choice. Such recording should be useful for self-evaluation and learning for the CNP, as well as for peer review and agency auditing as necessary. It seems particularly expedient to have this phase of planning recorded in a practice where there are so few tried and proven therapies.

Figure 13 presents an example of a form prepared for recording the reasons for choosing a particular intervention and shows an example use of this form.

Planning Purposeful Goal-Oriented Activities

The CNP, involved in a variety of community problem-solving efforts, needs a means of recording planned activities in the context of the problem or goal to which they relate. Figure 14 illustrates a form designed for this purpose. A column titled comments is included to permit the CNP or peers to later reflect and comment on the plans. An example entry is shown.

Intervention

The CNP may be involved in a variety of activities over a long period of time which may relate to one or many problems. In order to keep track of progress, notes are recorded according to the problem or goal to which they refer. CNPs are encouraged to write progress notes according to the NAP (narrative, assessment, plan) format. Such a format permits one to describe the activity or encounter, write an assessment of it, and note any plan that is an outgrowth of the activity. The plan may be transferred then to the Plan Form and dated. In this manner planning is kept up to date and pertinent.

An additional column for reflections and comments on the Progress Note Form, figure 15, was helpful. This column permitted the CNPs to write a later reflection regarding certain activities, thus promoting self-evaluation. An example entry on the Progress Notes is illustrated in figure 15.

Progress notes are kept in a file folder or notebook packet filler along with all of the record pertaining to one problem. The file includes the recorded goals and objectives, a problem analysis, inferences for intervention, planned activities and progress notes pertaining to the problem.

Evaluation

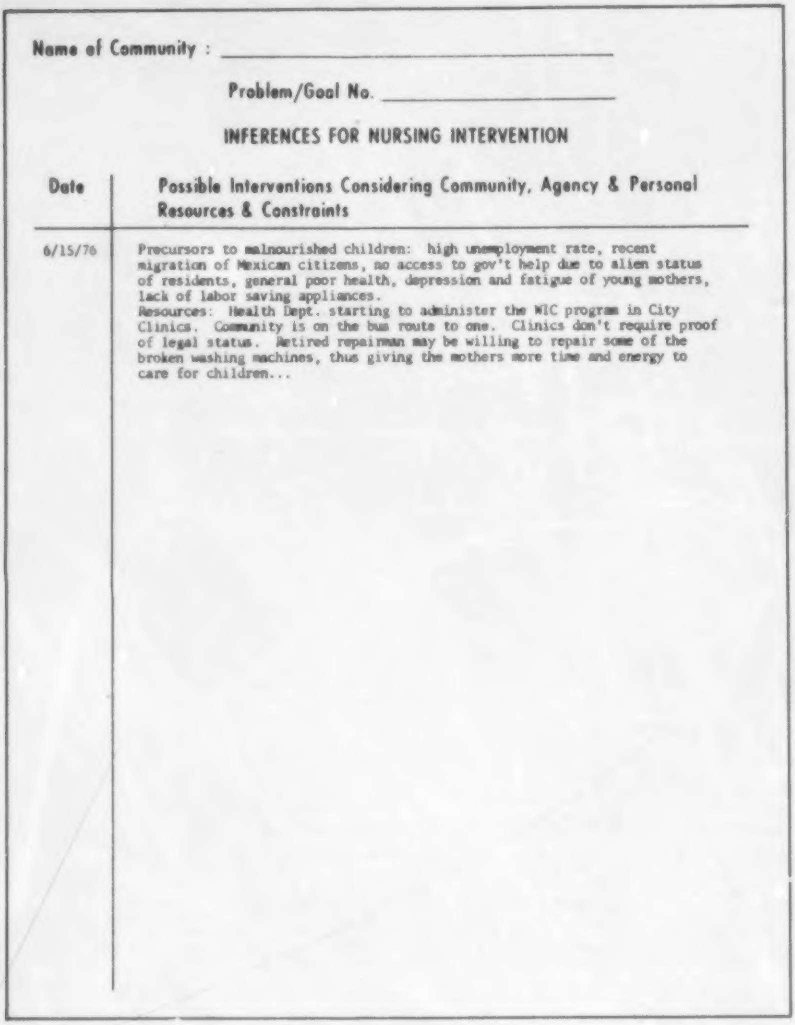
The community-oriented health record, as described earlier, was developed to structure evaluation into each phase of the planning and intervention processes. The intent was that the CNP develop measurable goals and objectives and evaluate progress toward these. Also, it was intended that the structured recording forms permit self-evaluation and allow for peer review throughout the process.

In summary, a community-oriented health record was developed to facilitate the community nurse practitioner's practice. The C-OHR experienced an evolution similar to that of the CNP program. Some aspects of the record developed early in the program and were well tested. Other parts, particularly the use of structured recording forms, are very recent developments requiring more use and testing.

The C-OHR as it is currently being used includes the following:

1. A data base for community health assessment recorded on Descriptive Data Recording Forms, and filed according to specific assessment categories in an indexed notebook.
2. A community problem list compiled and documented on a Community Problem List Form.

Figure 13.—Inferences for nursing intervention form with example entry



Name of Community : ____________________

Problem/Goal No. ____________________

INFERENCES FOR NURSING INTERVENTION

Date	Possible Interventions Considering Community, Agency & Personal Resources & Constraints
6/15/76	Precursors to malnourished children: high unemployment rate, recent migration of Mexican citizens, no access to gov't help due to alien status of residents, general poor health, depression and fatigue of young mothers, lack of labor saving appliances. Resources: Health Dept. starting to administer the WIC program in City Clinics. Community is on the bus route to one. Clinics don't require proof of legal status. Retired repairman may be willing to repair some of the broken washing machines, thus giving the mothers more time and energy to care for children...

Figure 14.—Plan form with example entry

Name of Community : ____________________

Problem/Goal No. ____________________

PLAN

Date	Number	Plan/Activities	Comments (dated)
6/15/76	1	Begin to contact families with pre-school children to assess interest in forming a discussion/sharing group.	

Figure 15.—Progress notes form with example entry

Name of Community : ______________________________

Problem/Goal No. ____________________

PROGRESS NOTES

Date	Activity No.	NAP	Comments (dated)
6/20/76	2	N. Attended C.C. meeting - 20 residents attended. I explained about availability of WIC program. Many questions...	

3. Intervention plans recorded according to:
    a. Goals and objectives
    b. Problem analysis
    c. Inferences for nursing intervention
    d. Planned activities
4. Progress notes on the intervention recorded on a Progress Notes Form.

It is our intent that the C-OHR facilitate the practice of the CNP by structuring, recording, and monitoring all phases of that practice including: community assessment, problem identification, planning to intervene, the intervention efforts, and evaluation. In this manner we view the record as a potential tool for teaching a core of behavior to students and public health nurses desiring a community focus for their practice. Ultimately, we envision the record as a tool for improving the health of communities.

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Chapter 5

ATTITUDES TOWARD COMMUNITY WORK: A PRELIMINARY STUDY

Purpose

The preliminary study reported here was concerned with the effect of a 9-month learning experience on students' attitudes toward working in the community and with community groups. Questions raised were: Are the attitudes of these nurses toward community work different from nurses who choose graduate education in community health at a school of nursing? Do nurses enter the CNP program with positive attitudes toward community involvement? Do their attitudes change over the course of the program? Do the nurses' attitudes differ from other students (nonnurses) in the school?

Instrument

A questionnaire with descriptions of real-life situations, each of which illustrates a key concept of community work, was developed (see appendix B). The expectation was that attitudes toward these concepts, reflected in the respondent's response, would change, following the nurse's exposure to an educational program aimed at helping the student work with community groups. For those nurses who already had experience in this area, we expected either no change or a strengthening of positive attitudes.

The questionnaires were given to three groups of students: those enrolled in the Community Nurse Practitioner Program at the School of Public Health, nurses in a graduate program in community health at a nearby college of nursing, and one class of graduate students (nonnurses) in the School of Public Health.

A total of 52 questionnaires was completed. Table 6 subdivides the group (see page 79).

Procedure

Following development of the questionnaire, the authors independently coded each question as to the appropriateness of the answers in demonstrating positive or negative attitudes. A five-point scale was used, wherein five points were given for the most positive response and one point for the most negative. No answer or more than one answer was treated as a "neutral" and given three points. With the exception of one question which was removed from the study by mutual agreement that it was confusing, there was total agreement by the coders on their allocation of values to each answer. These agreed-upon values were used to score each questionnaire.

To retain anonymity, respondents used code numbers to identify their questionnaires, and these were retained by the project secretary. Further, anonymity was assured by the secretary's typing each person's answers to eliminate any scorer bias that might occur through recognition of the students' handwriting. It was these typed sheets which were scored.

Each question (situation description) was followed by the words: strongly agree, agree, neutral, disagree, and strongly disagree. The respondent was asked to check the one that most closely approximates his feelings about the situation described and how it was handled. The questionnaire was given to some of the students at the beginning of the academic year and some at the end. Written instructions preceding the questions sufficed. Each respondent took about 20 minutes to complete the questionnaire.

Following is information about each of the situations described, including a brief rationale for its inclusion, as well as discussion of the key concept(s) and particular attitudes it was hoped would be elicited.

Question 1. Citizen Participation

At a recent meeting of the Metropolitan Hospital District, the Chairman of the Board complained that the patience of the Board was being exhausted by the continual stream of citizen complaints regarding the functioning of a very minor component of the Hospital District, namely, the neighborhood health centers. After all, the Board dealt with the multimillion dollar problems of the District as a whole very efficiently. Why should they have to spend so much of each meeting on such a relatively small operation?

This situation illustrates a directive rather than a developmental approach to problems in the community. There is limited participation allowed by the Chairman and there seems to be limited input from the citizens into the decisions of this board. There is no attempt to get at the "real" causes of these continuing complaints; no attempt is made to listen to the citizen, much less invite his participation.

According to Glogow, "Barring a backlash toward a repressive political state, one can predict that the movement by people to have a greater voice in their lives will continue. . . . Citizen participation appears to be here to stay *(1)*." People have renewed interest in determining their own futures. Notwithstanding mandated participation, as consumers of effective services they must be full partners in decisions affecting them.

Students who disagreed with the statement were seen to have positive attitudes toward the inclusion of citizens in the decision-making process.

Question 2. Development

The allegiance of the community worker is to the agency for which he works. Although he is serving in the community with a genuine commitment to the community's needs, in case of conflict situations he should make it clear to the community that his first allegiance is to his agency.

The worker's first commitment is to the persons in the community: to the development of their abilities to make informed decisions to solve their problems. In the community approach to development there is concern for all the people in the community and for total community life. It is based upon the philosophy of self-help and direct participation *(2)*. The attitude that the worker serves the agency first is incongruent with this approach. His first allegiance should be to the community: to strive for a holistic, developmental approach.

Those who disagreed that the worker's first allegiance was to the agency were seen to have positive attitudes toward a developmental approach to community work.

Question 3. Accountability

To help set a direction toward independence and establish some movement toward it, community workers should help neighborhood organizations hold the agencies serving them accountable for the way in which they provide their services.

Concern for validating the effectiveness of services through evaluation methods that are relevant and reliable have been increasingly expressed from all sectors—community residents as well as health professionals. The concept of accountability is being discussed at virtually every professional meeting that addresses "issues." And the question, "To whom is the community worker (nurse, therapist, etc.) accountable?" is being asked from many quarters.

In the statement dealing with accountability we are also bringing out the advocacy role of the community worker, that is, the worker as spokesperson/ally for the community.

The respondent who strongly agrees with this statement recognizes the necessity of involvement of the people in determining the relevance of services and the critical necessity of providing feedback to the agency about how those services mesh with community needs and desires.

Question 4. Egalitarianism

The rich and the propertyless, the scholar and the dropout, the mighty and the powerless, the common people and the uncommon—all are competent and capable of managing the affairs of a free society. Competence grows by daily use.

This example describes a belief in the equality of all persons. The attitude toward an egalitarian system may be seen as opposite that of an elitist: that some people, by virtue of education, station, color, sex, etc., are inherently more competent than others. This elitist attitude sometimes is expressed in a "professionalism" which comes across as, "I have the degree and expert knowledge; therefore, what I think your needs are carries more weight than what you think."

Strong agreement with the statements reflects an egalitarian belief in the human spirit and was seen as the most positive attitude.

Question 5. Democratic Process

The tendency to dominate is to be found in all human relationships. In many social situations this is good; someone must assume the responsibility of leadership and power. Early in the community work process, the worker often needs to dominate until the initiators of the group have gained enough self-confidence to carry the process on. However, instead of working to increase his power over the group, he deliberately diminishes that control. His faith is not in himself and his professional expertise but in the process that citizen participants come to dominate.

Although democracy is often difficult to achieve in its purest form, it is a goal toward which to strive. "Ideally," according to Wileden, "it would broaden the basis of planning [community work] to the point where every concerned individual is involved (*3*)."

This description provides an example of the flexibility needed for community work. That is, although the worker may believe in the democratic process, he may need to use seemingly opposite styles to achieve the goal of broad-based participation by all involved.

Those who strongly agreed with the statement are seen as having positive attitudes toward the democratic process.

Question 6. Cooperation in Change

One experienced community worker puts it this way—"I have been affiliated with more than one institution that was dedicated to serving the community. Perhaps I'm getting too cynical in my old age, but underlying the assumption of institutional service may well be a measure of paternalism and arrogance. Particularly when colleges serve communities, it's pretty clear who serves whom—who receives services and who donates them. I don't think I'm dabbling in semantic antics here, I'm concerned about the assumptions that sometimes parade behind the service concept of we've got information, skills and knowledge which you out there need and we, in grandiose altruism, are willing to contribute to you."

The concept of collaboration or cooperation versus exploitation is clearly illustrated. Goodenough speaks to this as he begins to introduce the concepts of development, saying, "Development that is undertaken in the spirit of imposing our will on others or getting them to see the folly of their ways and the wisdom of our counsel inevitably meets with resistance (4)."

Cooperation and collaboration rather than a paternalistic, "we'll take care of you," approach is congruent with the goals of development. Strong agreement with the concerns of the speaker is viewed as reflecting positive attitudes toward cooperation and collaboration between community worker and the community.

Question 7. Blaming the Victim

A major pharmaceutical manufacturer, as an act of humanitarian concern, has distributed copies of a large poster warning 'Lead Paint Can Kill.' This poster, featuring a photograph of the face of a charming little girl, goes on to explain that if children eat lead paint, it can poison them, they can develop serious symptoms, suffer permanent brain damage, even die. The health department of a major American city has put out a coloring book that provides the same information. While the poster urges parents to prevent their children from eating paint, the coloring book is more vivid. It labels as neglectful and thoughtless the mother who does not keep her infant under constant surveillance to keep him from eating paint chips (5). These are two worthwhile programs.

"By a process of causal inversion, the victims of poor planning come to be treated as if they created the situation in which they find themselves (*6*). So state Caplan and Nelson in their discussion of the person-blame bias of social science. As Ryan points out in his seminal work on this subject, no one would argue against spreading knowledge of the danger of eating lead paint; however, "... to campaign against lead paint *only* in these terms is destructive and misleading . . . (*7*)."

The approach to solving a community public health problem described here is to blame the person(s) affected (in this case, the family of the child who eats lead paint) rather than mobilizing efforts against what are perhaps the two major "culprits"—the manufacturers of lead paint and the landlords who refuse to paint over peeling walls. The assumption is that as long as we place our efforts into blaming the "victim," the real causes will go untouched and, therefore, efforts to eliminate the problems will be thwarted, and workers as well as community residents will continue to be frustrated. Strong disagreement with the statement that these are worthwhile programs points to an attiude that is not inclined to blame the client for misfortunes beyond his control.

Results

Although nonnurses enrolled in the School of Public Health did not participate in this study to the extent of completing the questionnaire both before and after their educational program, a group did volunteer to fill it out on a one-time basis. This was done at the beginning of the school year. The group was comprised of a mix of students who were all taking the core course, Bases of Community Health, which is required for all students. The scores of these nonnurse students were analyzed in comparison to the scores of nurses enrolled in both a college of nursing master's program in community health (CHN) and in the Community Nurse Practitioner (CNP) Program. The single scores of the nonnurses were compared to the single scores of the nurses. Using the Wilcoxon Rank Sum for the comparison of two groups in independent samples, there was no statistically significant difference found in the scores of the two groups ($p > .05$) (*8*):

	n	*Sum of ranks*
Nurses	23	475
Nonnurses	14	202

Comparison of pretest scores between nurses in the CNP program and those in the CHN program did not reveal any statistically significant difference ($p > .05$):

	n	*Sum of ranks*
CNP students	11	146
CHN students	12	130

It was felt there might be a difference in questionnaire scores between the nurses who took both the pretest and posttest and those who only completed the pretest (they were all invited to participate in the posttest). The Wilcoxon Rank Sum Test demonstrated no statistically significant difference between the two groups' pretest scores ($p>.05$):

CNP and CHN students	*n*	*Sum of ranks*
Pretest only	9	91
Pretest and posttest	14	186

Seven nurses who were enrolled in the CNP Program and seven nurses enrolled in the graduate program in community health nursing at a nearby college of nursing completed questionnaires both at the beginning of their programs of study and at the completion. Changes in scores should reflect changes in attitude so that positive changes reflect more positive attitudes and negative changes more negative attitudes.

Overall change scores in the CNP group show a positive shift with one exception, which dropped one point. There was a statistically significant difference in pretest and posttest scores for the CNP students (*9*).

In the CHN group three students shifted to more positive attitudes, while four reflected more negative attitudes in their answers. The shift of attitude in this group over time, however, was not statistically significant. The results are summarized:

	n	*Sum of negative ranks*	*Sum of positive ranks*	*Result*
CNP students	7	1	27	$>.02$ $p<.05$
CHN students	7	13.5	14.5	$p>.05$

There was a statistically significant positive shift in attitude scores for the CNP students but not for the CHN students. When the differences were compared, there was also a statistically significant difference between the two groups ($p<.05$) (see below). The scores from these two groups provide some evidence of a difference in distribution of attitude change between the CNP and the CHN students:

	n	*Sum of ranks*
CNP students	7	69.5
CHN students	7	36.0

Conclusion

Any attempts to address the answers to questions which prompted this preliminary study with the data gathered to this point would result in tenuous, at best, conclusions. Since the samples were convenient, and sample size quite small, no more powerful statistical tests could be applied, and there will be no generalizations from these "findings." However, we may learn from the two comparisons, which showed some measurable differences. One, nurses who choose to enter a school of public health for their master's degree may hold different attitudes toward community work than do those who choose to attend a school of nursing. Whether these are more positive attitudes remains to be demonstrated. Second, the fact that CNP students demonstrated a greater change in attitude from the beginning of their academic program to the end, most probably is related to the program in which they were enrolled. The focus of the CNP curriculum is upon working with others in the community, so that much of the content and experience of the program are aimed at just the attitudes we were attempting to measure.

That this preliminary study is a first tentative step toward measuring the aforementioned attitudes does not need reiteration. Were the study to be carried another step, it would be in the direction of validating further, one, that these attitudes are valuable in community work, and, two, that in fact these descriptions tap the identified attitude. Further work in developing the test would certainly be in the offing, as would an exploration of possibilities for the tool's use in evaluating the educational program. Staff members welcome contributions and criticisms from those who share similar interests.

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Table 6.—Community Attitude Questionnaire respondents

	Pretest only	Pretest and posttest	Total
CNP students in School of Public Health	4	7	11
CHN students in College of Nursing	5	7	12
Nonnurses in School of Public Health	14	--	14
Total	23	14	37

Chapter 6

EXPERT PANEL REVIEW OF COMMUNITY NURSE PRACTITIONER PROGRAM

Introduction

In the spring of 1976 staff members contacted 15 individuals and requested them to respond to a series of questions dealing with certain aspects of the CNP Program. The individuals were chosen, using the following criteria:

1. a demonstrated interest in innovative approaches to the solution of health problems in the community;
2. sufficient expertise in either education or service in community health (that is, staff either knew of endeavors in this area from personal experience, or had written evidence of such through publication); and
3. a willingness to commit 2 days to the materials and questions from the CNP staff.

Additionally, there was an attempt to choose persons from various disciplines, and from a variety of agencies, although there was an emphasis on a greater representation from nursing.

All persons contacted responded enthusiastically in the affirmative. A list of the consultants, with a short description of their particular field of expertise, follows:

Name	*Title*	*Expertise/Interest*
Nita Barrow, R.N., R.M.W.	Director Christian Medical Commission, Geneva, Switzerland	International perspective; community development, experience
Caroline Blass, R.N., M.P.H.	Director of Nursing Harris County Health Department, Houston, Texas	Employer of CNP; public health nursing

Name	*Title*	*Expertise/Interest*
James B. Cook, Ph.D.	Instructor, Department of Regional and Community Affairs, University of Missouri, Columbia	Community development; political science
Beverly Flynn, R.N., Ph.D.	Associate Professor and Director of Graduate Program in Community Health Nursing, Indiana University	Graduate education in nursing; evaluation
Loretta C. Ford, R.N., Ed.D.	Dean and Director of Nursing, University of Rochester, School of Nursing, New York	Practitioner education; new nursing roles
Dorothy Huskey, Ph.D.	Professor, Health Education, Sam Houston State University, Huntsville, Texas	Health education; community development
Lucie S. Kelly, R.N., Ph.D.	Professor of Nursing, Columbia University, School of Public Health, New York	Nursing; curriculum development
Jeane Knight, R.N., M.S.	Associate Professor, University of Texas, School of Nursing, Galveston	Undergraduate education in community health nursing
Hardy Loe, Jr., M.D., M.P.H.	Director, Southwest Center for Urban Research, Houston	Health care practice; health planning
Stephen N. Rosenberg, M.D., M.P.H.	Assistant Professor, Columbia University, School of Public Health, New York	Public health practice

Name	*Title*	*Expertise/Interest*
Hope Sessions, R.N., M.Ed.	Director, Nursing Division, City of Houston Health Department	Employer of CNP; public health nursing
Carol Spengler, R.N., M.S.	Director, Department of Nursing, Mid-Missouri Mental Health Center Columbia, Missouri	Public health/mental health nursing practice; administration
Virginia Thompson, R.N., M.P.H.	Director, School Health Program, Houston Independent School District	School nursing; administration
Carolyn Williams, R.N., Ph.D.	Associate Professor, University of North Carolina at Chapel Hill	Epidemiology; nurse practitioner roles; evaluation

These consultants were sent a packet of materials and a list of questions relating to that packet and were asked to return their answers by June 15. The complete packet consisted of: article from AJPH, curriculum description, UTSPH Catalog, list of questions, and master's projects of two graduates. The curriculum description is included in chapter 2.

Following is a summary of the consultants' responses. Unfortunately, two people did not return their written responses in time for review; so these are not included. When the consultant is quoted directly, the statements will so indicate; however, individuals will not be identified in order to protect their rights of privacy.

The summaries will be divided into six broad areas similar to the questions asked of the experts: (1) need for the CNP role; (2) feasibility of implementing some or all of the curriculum into basic nursing education; (3) feasibility of implementing some or all of the curriculum into continuing education programs for nursing; (4) implications of the CNP program for the preparation of physicians, statisticians, health educators, health planners, and other health professionals; (5) implications for employing agencies; and (6) overall reaction to the materials.

Need

Although all consultants agreed that there is a need for the type of practitioner being prepared in the CNP program, their view of what has stimulated the need varies in critical areas. Several point out that health professionals are, for the most part, prepared for highly skilled and technical specialities in diagnosing and curing people; that continuing to treat pathology without considering the cause is self-defeating; and that the emphasis on individuals and families creates health programs which are duplicated, overlooked, and inaccessible to populations at risk. They highlight the need to effectively promote health at the aggregate level through individuals with broad insights, knowledge, and skills reflected in the CNP curriculum. As one consultant noted, "Economic factors alone should demonstrate the need to shift the emphasis from primarily treating people who are ill to working with individuals and communities to promote and maintain their health."

Another area stressed was community development. According to one nurse, ". . . society's greatest need is not so much for greater numbers of nurses as for nursing roles which aim more at reducing causes of disease, promoting health, and facilitating individuals, families, and communities in solving their own problems . . . ." Another consultant reiterates, "In working with a number of local governmental health agencies, I have noticed that the most effective health professionals often achieve agency goals (and community goals) largely through the application of community development methods."

The need for communities to learn the processes of self-determination arises, according to one consultant, from a "growing reliance on external forces (government, commerce, professional health workers, organizations, institutions, etc.) rather than internal resources of self and group to solve health problems." Others concur, pointing to the necessity of allowing and encouraging people to carry the major responsibility for their own health in order to increase their dignity. Additionally, "Populations need to value and gain control over their own health matters, become decision-makers and partners in planning, implementing, and evaluating health care delivery systems, and create positive impacts on legislation and regulatory agencies to reach mutually agreed-upon, broadly conceived health goals."

Finally, there is an expressed need for a public health worker who does not have the solutions in his pocket: a person with a problem-centered orientation. Most health professionals, it is pointed out, think primarily in terms of specific types of solutions; each is oriented toward the techniques of medical care, environmental sanitation, health education, or some other "answer." The consultant who addressed this need expressed the view that the CNP program, ". . . trains people who will look first at the question without a preconceived commitment to what may or may not be the answer."

The needs identified may be summarized as four dichotomies:

- population versus individual focus
- problem orientation versus solution
- professionally defined "service" versus community development
- individual responsibility ("self health") versus external controls.

There appears to be agreement among the consultants that the philosophy and goals of the CNP are directed appropriately toward the above issues, and that the need for such a practitioner is "obvious."

Implications of the CNP Role for Employing Agencies

This broad heading is subdivided into specific considerations, each of which will be addressed separately.

Type of Agency

Almost every type of agency which deals with health and social services was listed under this question. Most consultants agreed that potential employers of CNPs represent a wide range of agencies, such as local government public health agencies, HSAs, neighborhood clinics, HMOs, military health services, home care agencies, family planning agencies, hospitals, schools, and planning agencies. One consultant recommended that the CNP be employed by several agencies at one time or that the CNP contract his or her services to a community as an independent practitioner. Models such as those supported by foundations in long-term international projects or short-term Government projects, e.g., Peace Corps, were suggested as applicable. "Theoretically," according to one expert, "the most productive relationship would be one in which the community itself chose to employ a practitioner with the explicit goal of learning new ways to approach group problems."

One consultant warns, ". . . the agency which clings to the 'status quo' attitude will not be the one [for the CNP] to depend upon as a future market . . . ." In addition, due to the focus of the CNP role, one consultant feels it would not be appropriate to include this position under a "traditional public health nursing program." She suggests separate divisions of public health nursing ("traditional") and community health nursing (emphasizing the CNP approach).

The suggestion to implement the role in a department of health is discussed in some detail by one consultant. Her comments are included below to explain how, and why, this might be done:

I would suggest implementing the CNP role within the department of health for several reasons. First of all, it is an established State-funded agency. Consumers and health providers alike are confused and often uninformed about the vast number of different agencies that provide a multitude of human services. It would therefore be more expedient and more economical to establish CNP positions in an agency that is already operational and well known, rather than another new and different one. Ideally, it would be most beneficial if local communities would determine for themselves that such a provider as the CNP was needed and necessary and would set about establishing a position locally. Unfortunately, those communities that have the greatest health needs and would benefit the most from the services of the CNP are the least well organized in regard to determining such needs and have minimal resources available. Since the major role for the CNP is to discover with the community what its health priorities are, what resources are available and what would be an effective and acceptable manner to approach the problem, it seems reasonable to expect that the State would be responsible for providing the major source of funding for this type of health care provider. This would also guarantee that communities throughout the State would have an equal opportunity for the service of CNPs.

Relevance to Agency's Goals

"Most health agencies have in their . . . goals . . . their programs' roles in improving the health of the community. The CNP role is aimed at helping the community to help itself through the process of educating community citizens to articulate their health needs and suggest alternative solutions to health agencies." The consultant who wrote the preceding statements summarized most of the responses to this question. Others pointed out that the agency's goals would influence how the CNP role could be implemented, but that with a CNP, programs could become more consumer oriented and community based. Still another emphasized that the CNP's skills are most closely related to the goals of local governmental public health agencies: "City and county public health departments, ideally, begin with interest in and responsibility for safeguarding and improving the health of a geographically defined community."

Important Aspects of the Role to the Agency

Several consultants mentioned health promotion and the linkage aspects of the role as critical. One brought out that an important aspect of the role is the contribution it brings in developing perspective in programming, That is, in addition to working with community groups, working with direct-care colleagues in efforts to assist them to see commonalities in clients or potential clients. Another important aspect is that of helping citizens to exercise their influence in forming health policy, including keeping up to date on Federal and State legislation and identifying options within them.

There were no "least important" aspects mentioned; however, a potential conflict between the two major goals of the CNP program was discussed by one person:

> On the one hand, your program attempts to train practitioners who will not approach a community or a problem with a preconceived bias toward any given mode of intervention. . . . The excitement and importance of 'real' public health lie in its freedom from the limitations of any single category of intervention. On the other hand, CNPs *are* trained rather vigorously in one particular kind of intervention—community development, fostering 'self-health.'
>
> As I began reading your materials, I welcomed the learning of CD skills as a very useful *addition* to the kinds of interventions which public health professionals already understand. The skills of CD are also extremely useful in developing and maintaining a relationship between the CNP and her (his) community, and in working with that community to define problems and set priorities. However, once the CNP and her(his) community are ready to consider interventions, these interventions *can not* be limited to the community development efforts exclusively.
>
> I realize that the CNP program does not intend to limit its graduates to CD interventions exclusively. There is this danger, however, in the very heavy emphasis on CD. I raise this caveat because, in picturing possible roles for CNPs in local health departments, I see that their problem orientation would enable them to meet community needs by mobilizing and coordinating a wide range of public health services—both traditional and innovative—in a meaningful way.

Facilitators and Barriers to Role Implementation

Four major facilitators were discussed:

- Skill and understanding of the CNP in working with a diversity of people in both the community and the employing agency (this would include a firm background in group dynamics, as well as a thorough understanding of the role);
- Understanding of the role and active support by "significant individuals," not only other nurses, but all other disciplines who work together to carry out the various programs of the agency;
- The CNP's understanding of the functions, purpose, and organization of the agency; and
- Consumer demand for participation in health programs.

Several consultants brought out factors which, depending upon whether they were written in positive or negative terms, could be either facilitators or barriers to the role. These factors were agency flexibility ("inversely related to agency size," in one consultant's experience) and clear delineation of communication channels; that is, organizational aspects.

Barriers for the most part focused on role expectations and acceptance by other health professionals, notably nurses "entrenched in traditional patterns," and physicians. That health agencies are physician controlled was pointed out as a barrier by one person, because "most physicians have been educated according to the traditional medical model which does not focus on community health. . . ." Also, from a physician, "There may be some M.P.H.-trained physicians who will see the CNP as a threat to their own 'turf.' "

Other barriers mentioned were the relatively indirect nature of the role and the difference in orientation regarding definitions of health between the CNP and other health professionals. The former seems to relate to an earlier-recognized facilitator; that is, it points to the need for the CNP to understand and to be able to clearly articulate his/her role to others. Elaborating on this, one consultant's views follow:

> A major barrier can develop if agency staff does not have the right concept of the role of the CNP or if proper planning has been overlooked in introducing the new role model to the group.
>
> If the CNP 'just appears' and receives no direction or support initially, or if the administration of the agency is fuzzy as to what the CNP concept is, then there will be additional problems. The CNP as well as the staff will be confused and possibly feel threatened.
>
> The personality or attitude of the CNP will be an important factor in whether the concept can be facilitated or whether more road blocks will be developed.
>
> An inquiring, searching approach in relation to peers would seem appropriate. An effort to build an air of confidence and interest, as well as a good team relationship, cannot be stressed too much.

Conflict between the community's and the agency's priorities was seen as another possible barrier. For instance, the agency hiring the CNP may be focusing on one thing (planning for a vaccination program) and would not desire the CNP to direct her efforts away from this priority.

The issue of economic viability was included by one consultant under this question. Proposed national health insurance, with its fee-for-service focus would not pay agencies for the role of CNP, she points out. "Health legislation may need to be proposed to assist communities and agencies defray such cost. Expenditure of monies for CNP services may prove cost effective for the tax dollar."

"The central factor in facilitating role implementation," according to one consultant, "is the communicative skill of the incumbent." He continues:

> In writing and speech, the CNP must have the capability to describe the role and the spirit of the premises and principles on which it is based. Yet, perhaps more important is the capability to communicate the nature and content of the role by behavior. The CNP bears the greatest burden in facilitating role implementation, though certain preconditions must exist within both the employing agency and the host community. There must be a level of anxiety and

discontent with existing conditions and systems to the point experimentation with new experiences and modes of operations are perceived as appropriate.

Placement in the Organizational Structure

Several consultants stressed the need for the CNP to work within the nursing division or department. In one consultant's words:

> I recognize that placing the CNP within a separate division for nursing is a rather traditional viewpoint when one considers that in this role, in order to be effective, the CNP will need to work closely with a multidisciplinary group of health and community workers. My reason for this is based on my own experience in our work setting where we have established a community mental health nursing department. While all community workers have some overlap in role functioning, we found that each group has a core knowledge base grounded in a particular discipline. While collegial relationships are fostered in the work relationship that cuts across all disciplines, peer review and support is a necessary aspect to functioning in a new autonomous and expanded role. We found that this was enhanced by having an organized community nursing department that worked closely with the Center's Community Program.

Within the nursing department, however, there was a range of views as to where the CNP would function most effectively. "The easiest role in terms of implementation, fulfillment, and lack of organizational stress produced," according to one consultant, "would involve the use of CNPs as low-level, semiautonomous, trouble shooters." He does not, however, advocate this as the most desirable role, discussing further the possibilities of a CNP as a regional director (supervising nurse), relating to groups such as town councils and unions, or as a district health manager. In discussing the above possibilities, the consultant elaborates: "It might be extremely interesting to find local health departments in which CNP career ladders could be structured: hiring several CNPs as trouble shooters for high priority geographic problem areas (under nursing division supervision) with advancement opportunities akin to the sub-regional and regional nurse."

Within the nursing unit other "titles" were listed to suggest where the CNP might fit. One option would be for the CNP to serve as consultant to the nursing director and staff; another might be to set up an office of coordination or liaison for program development and community relations. This last mentioned position was seen as having the same status as other units, e.g., Home Care Coordinator. Yet another suggestion was to restructure the traditional role of nursing supervisor to include some mechanism for handling the administrative busywork.

Regardless of agency size, the CNP should have a "top level" position; the position should be equal to (and not subordinate to) the administrator responsible for community health programs. Whatever the title given to the CNP, "It seems advisable in organizational structures to assure flexibility, stature and authority (via competence, not line authority), adequate time frames for production, fluidity in roles and relationships, administrative support and accountability measures. . . . The agency should be willing to allow the CNP to relate to his/her discipline but also to form linkages with other disciplines appropriate to his/her functional projects."

"Since the CNP role is a flexible one," a consultant points out, "it should be allowed movement in the organizational structure." He elaborates:

> Functionally, over time, the role will shift its connections within the agency. Formal assignment to particular sections or programs for housekeeping, fiscal responsibility, and other internal organizational matters are no great problem as long as movement, communication and access throughout the organization is permitted. Operationally, the role rests at the boundary of the organization, since the site and center of work lies in the community structure. Yet the specific types of involvement and the content of interactions within the community may require internal working relations deep in the organizations. This makes it difficult to fashion some general rule about the most practical location of the role in an organizational charting. Given different situations, it might be logical and effective to attach the role directly to the office of the agency director in one case and to a program field unit in another.

Specific Qualifications and Salary

Most consultants felt a master's degree and clinical or community experience would be most desirable. One mentioned that all qualified public health nurses are expected to have basic understanding of the concepts espoused in the CNP role, so that a background in public health nursing may also prove valuable. All mentioned experience as important when discussing salary range. Although reluctant to state a specific salary for the CNP, the suggestions ranged from $12,000 for a "beginning" master's prepared nurse to $22,000 for those with more advanced experience. Geographic location was mentioned as an important determiner of salary, as well as the type of responsibility to be assumed.

Job Description

> The development of an appropriate job description has to have a base in the existing conditions within the employing agency and in host communities. There are always responsibilities within the agency that must be bundled in the job description, and since it is likely at this stage that the CNP will be a relatively new kind of position, it is very important for the context of the employing agency to be taken into account in the initial structuring of the

job. However, more important is the working out of the job elements in the context of the communities.

To do this, the CNP has to be involved in evolving a particularized job description.

One employer suggests that the job description should be developed collaboratively by the nursing administrator and the CNP; it should be a "joint venture," and "a learning experience for both parties." Specific suggestions as to what that description should include were listed by others and are summarized below:

- Conduct an in-depth community assessment with the aid of community residents and keep it updated on a regular basis;
- Keep up to date on Federal and State legislation;
- Serve as a link between the community and the agency;
- Conduct a continuing outreach program to community agencies and groups to—
- Delineate the community's priorities for agency programs;
- Provide direct feedback to agency decision makers;
- Provide information to community citizens about health legislation, agency programs, etc.;
- Promote the concept of self-help;
- Help develop, implement, and evaluate pilot programs in the community "to suggest economically viable alternative solutions for meeting community health needs."

One consultant listed responsibilities of the CNP to the agency that specify, similar to the job description above, some of the tasks of the CNP:

- Identify with appropriate persons a specific community with which to become involved;
- Specify to the agency the ways in which the CNP plans to initiate and develop his/her community involvement;
- Write goals and measurable objectives which outline a statement of what is planned for a period of a year;
- Keep problem-oriented records on the progress being made by the community; and,
- Periodically evaluate progress toward goals and objectives.

One consultant relates:

> The responsibilities focus on systemic development within the community. Specifically the responsibility is to support activities that will increase the capacity of the community structures to satisfactory deal with the questions of public health taken in a broad sense. Particular responsibility relates to expanding the capacity of the community to use the energy, intelligence, and experience of people in the community in a type of participatory process which not only contributes to better policy, programs, and conditions affecting community health but expands the abilities of the people taking part to use them-

selves effectively in community or public affairs. The strategy is to aid, supplement or create situations in which people have the opportunity to learn in interaction with other citizens, professionals, and an array of resources. There is the responsibility to support structuring that will help translate knowledge, ideas, inputs, learning, etc. of individuals, organizations and groups into systemic intelligence.

According to another consultant, "The issue of job description/responsibility raises another issue: are we really talking about a role, or a set of insights/skills which would be useful to people occupying a variety of roles?" Further, she states, ". . . I don't see the insights, knowledge, and skills inherent in your curriculum as unique to nursing . . . [but] they are philosophically consistent with community health nursing practice, although infrequently demonstrated by that practice."

CNP staff members are in agreement with these statements and have considered this issue at some length. The insights, knowledge, and skills are not unique to nursing, but what the nurse brings to the role in terms of health knowledge and attitudes toward holistic and humanistic approaches to health problems provides a natural base from which to build this role. As the same consultant (above) points out: ". . . with his/her background the nurse might bring certain data/concerns to the attention of the aggregate for validation/consideration . . . given their background they might attend to certain data that others would miss or avoid."

Interdisciplinary, Intraagency, and Interagency Relations

Most agreed that an important aspect of the role of the CNP "should be to communicate and collaborate with a variety of other health care and community workers." Additionally, a need for support from other disciplines was felt to be vital, "Since a community's health is a broad consideration [the CNP] needs to develop good relationships with other professionals. This is important if [the CNP] is to provide adequate and effective linkage between the community and its suprasystem."

Several consultants stressed the need for the CNP to "educate the agency" regarding the CNP role, and stressed that this can only be done if the CNP has a thorough understanding of the formal and informal relationships within that agency and between agencies. The CNP needs the support of her agency—"someone to go to for advice and encouragement"—and will need to cultivate this support by establishing his/her credibility. This could be done by the already-mentioned establishment of good working relations, as well as by gaining a clear view of the role and how it might be implemented in that particular agency.

Possibilities for Implementation

One consultant predicted that, initially, implementation of the role in an agency would be met with "resistance, doubt and some criticism . . . not necessarily because of the role itself but rather because it represents a change from that which is more traditional and therefore more familiar." She states further:

> Change always produces some anxiety in a system and therefore must be dealt with in an effective manner. Because the CNP has been prepared to be a cooperator in change, he/she should have a basic understanding of the change process and how to facilitate change in the most constructive manner. This is no small task and there will be many frustrating aspects to implementing this new role. If the CNP is sensitive in assessing the agency in much the same way as he/she would the community, and proceeds thoughtfully, not overzealously, anxiety and therefore resistance will be minimized. Open communication and accessibility to others will assist immeasurably in implementing the CNP to its fullest potential.
>
> In summary, the future of any new role, including the CNP role, will be successfully implemented on a long-range basis if it is viewed by others as an important and viable role. To a larger degree this will be dependent on each individual practitioner. Support within the agency and within the community by significant people will be important in implementing the role; however, the community nurse practitioner will have to prove the merit of the role through his/her own practice over time.

Long-range possibilities for implementing this role are yet to be demonstrated. As one consultant states: "It appears to be an educative process between community citizens, the CNP, and agency personnel and policymakers. Through this process there should be closer congruence between agency priorities and community priorities in relation to health care needs and programs." Another consultant's views are quoted below:

> A lot of the short- and long-term possibilities for implementing the CNP role depend on the degree to which interdisciplinary and interagency effort is acceptable among the health professionals and health institutions surrounding the specific communities. Since the CNP is a nurse and identified as a health professional, the role will be tied into the health establishment. This has tremendous advantages in establishing the role, but there must be a response supportive of it or it will never get off the ground.
>
> What the prospects for implementation are will vary depending on the ideals, values and expectations of those making predictions. If there is a belief that democratic processes (opening community decision-making to those who would participate on their own volition) are to be desired and can be effective in this technologically dependent society, then the outlook for implementing the CNP role would seem excellent. On the other hand, if the belief in modernity has outmoded democracy, at least as a system of open participation, then the role would be thought a step in the wrong direction and unlikely to be successfully carried off.
>
> The CNP role has to be considered an experiment in any case, and there is never any certainty of how an experiment will turn out. Yet, there is a lot of room for optimism about the CNP role.

That "Most employing agencies are not prepared to accept [the CNP's functioning] operationally," is discussed by one consultant:

> At the philosophical level, and with the traditional American value placed on having citizens involved in public life and public programs, agency administrators, professional personnel and boards of directors often will find the concept of the CNP role appealing. There might well be considerable support for introduction of such a role to build a workable link between agency planning and services and the 'client' community. The problems are likely to arise when changes in the community structuring, levels of citizen activity and issues begin to develop in and around the focus of the CNP's involvement. It takes some time for agencies to become accustomed to the fact that communities do not perceive of themselves as clients of agencies and irrevocably tied to the agency network. Rather communities prefer to think from the perspective of looking at agencies as instrumentalities to secure some goods or services, and their concern is not with how people will fit the client criteria of the agency, but with how well the operation of the agency's services fit the criteria of the community.
>
> The fact is CNPs are likely to have contact with and engage with communities, segments of communities and organizations within communities who are not supportive of the employing agency. Even when the sponsoring agency employed the CNP with great expectations of broadening community contacts and expanding understanding of the community, it is likely that when the CNP deals with people, organizations and other agencies that are not fully supportive of the employing agency, the staff and directors can perceive this as a kind of cavorting with the enemy.
>
> In short, the CNP's job is relevant and fitting only in an agency able to consider its goals as subject to change and adjustment in the context of the communities in which it operates. Since there has been limited experience with professional roles like the CNP within many agencies, care must be taken that there is an understanding within the agency that the activation of the role is likely to result in pressures to redefine the agencies' purposes. For the CNP role to work, the host agency must not suffer under the illusion that broadened and/or intensified citizen participation within a community will have the effect of reaffirming the established objectives of the agency or expanding consumers for the existing complement of services.

Basic Nursing Education

A series of questions was asked under the heading, "Desirability and possibility of implementing some or all of the concepts and/or components of the CNP program into basic nursing education." These are addressed below.

Although the majority of the consultants addressed these questions from the perspective that baccalaureate education is "basic" nursing education, one specified that, "all three of the generic nursing programs [diploma, A.D., and B.S.] should include at least some of the basic community concepts identified in the . . . program." Also, "Since all three programs purport to prepare 'generalists' as opposed to 'specialists,' it would be in keeping with the educational goals to at least expose students to all types of practice areas."

Most of the consultants reacted positively to the question of the desirability of implementing concepts of the CNP program into basic nursing education. Several warned that this would of necessity have to be at an introductory level, for instance, one consultant remarked: "I think it is essential that undergraduates in nursing develop a broad perspective regarding the health of populations . . . [and that] such a perspective should be introduced early in the curriculum. However, I would make a distinction between developing an appreciation for the 'big picture' and developing *skill* in functioning in a manner similar to a CNP." Others agreed and recommended that the "practice," rather than observation, and "skill" portions were more appropriately developed on a master's level.

There seemed to be agreement that the CNP concepts are congruent with the major focus of baccalaureate nursing education today. The concepts of nursing process, self-health, and cooperator in change are seen as relevant to the students' learning with individuals and families. One consultant included an excerpt from her school's philosophy and found a goodness of fit between it and the description of the CNP role:

> People have inherent dignity and worth and the right and responsibility to actively participate, as they are able, in making decsions which affect their state of health. . . . Nursing, which evolves its practice in response to societal needs, is one of the interdependent helping professions committed to the prevention of illness and promotion of health. Professional nursing practice involves assessing health needs, and planning, implementing and evaluating nursing care for individuals and groups in a variety of settings. It is a scientifically based process devoted to helping individuals, families and groups make maximum use of their resources in meeting their respectve health needs.[1]

Another consultant concurred by pointing to the concepts inherent in integrated programs: individual, family, and community; themes of health; self-help; holistic care; and, partnerships with clients. However, this same consultant does not believe the basic nursing curriculums could do more than introduce and implement "on a small scale" community development concepts. She continues: "If an extensive effort is undertaken, then the students would need to have more time and social science theory. However, the attitudinal socialization of the student is tremendously important, and I prefer early involvement of the student in an ongoing community development project with students in other majors." She feels that increasingly complex roles could be handled by the student over time with the proper guidance by a CNP faculty member.

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[1] The University of Texas System School of Nursing Catalogue, 1975–76, p. 52.

Although, as one consultant brought out, a first priority of undergraduate education in nursing is the development of beginning competence in dealing with individuals, families, and small groups, this approach could be "enhanced by the self-help philosophy underlying the CNP program." She further states a critical issue which has surfaced repeatedly over these past 4 years: ". . . without sufficient time I doubt . . . [that the students] . . . could engage in the community development process. . . . I perceive that such a process takes attention over an extended period of time."

Aspects to Include in Curriculum

The following were identified as key elements to include in a basic nursing education program which incorporates some or all of the CNP concepts: (1) nursing process, (2) health promotion, (3) epidemiology, (4) community development, and (5) sociocultural factors.

Several responses supported threading the CNP concepts throughout the curriculum, one pointing out that, "familiarity with the community is required before any meaningful interaction can take place." The consultant continues:

> One just has to be there to grow to know and understand and care about the people; to know about community strengths and problems; to learn who are potential leaders, who is capable of influencing others in the community, who has a hopeful attitude believing that change can be brought about, etc. Just being there allows one to have chance encounters that may turn up important information or lead to valuable assistance.

Essentially in agreement with the need for community-based learning over a fairly extended period, another consultant expresses concern over having these philosophical notions introduced too early in the student's academic career:

> I wonder whether the students would be open to dealing with the broader arena in which the CD process is practiced before they are comfortable with their direct care clinical skills. For that reason and because I believe the key contribution of having such content in undergraduate programs is to develop perspective regarding the role of clinical services in the broader picture of health statuses at the aggregate level, I would see field experiences, additional theory, and guided participation in a phase of the process coming later in the undergraduate curriculum.

Barriers to Implementation

The most frequently mentioned barrier was the lack of qualified and committed faculty to serve as role models. Also brought out as barriers were the following:

- The "it can't be done" attitude from within nursing;
- Trends in some local areas toward more short-term, task-oriented physician-controlled nurse's "training";
- Barriers created by other health workers (namely the social worker) who feels "the community" is solely his/her province;
- No perceived need for such a role by many people;
- Emphasis on the care of the hospitalized patient and on assisting the physician;
- The time necessary to learn the concepts and skills (it would take a large block out of the curriculum, and it has not been agreed upon as to what can be left out or compacted to allow for it);
- Concern that students will not pass State Board Examinations if disease conditions are not heavily stressed; and
- The public's and the medical profession's image of the nurse.

In relation to the last-mentioned barrier, the consultant continued: "The public in general views the nurse as primarily belonging in the hospital setting. It somehow always seems more important to be saving someone from the very throes of death than to be saving someone from this same eventuality, but at a much earlier point in the process that leads up to it."

Faculty Qualifications

"Faculty should have skills in being a cooperator in change before they teach these concepts," according to one consultant. Others agree, pointing out a need to have a faculty with experience in community work, who can work within a very loose structure as practitioners themselves.

Specifically, several felt faculty should be health professionals with at least a master's degree and hold a joint appointment by the community agency and university. The major concern expressed was summarized as follows: "Faculty should be in tune with reality . . . realization of what the real world is like must be part of the process."

Methods of Teaching

Many methods of teaching were listed (e.g., lectures, seminars, self-study and independent study projects, and interdisciplinary team teaching); however, the one method most described as essential was a directed fieldwork component with faculty or preceptor role models.

Composition of Classes

All agreed that student/faculty ratio depended upon whether or not there was fieldwork included (in which case the ratio 5:1 was suggested) or if the course were covered in a lecture-type series. One expert (a faculty member) brought out the possibility of students working in groups (i.e., one group of four to eight students working in one neighborhood), and the need for faculty to know the community well, which precludes a faculty member from working with more than two groups at any time. (Note: This faculty member has attempted to implement several of the CNP concepts in a basic nursing program. See the article, "Applying Nursing Process in the Community," Jeane H. Knight, *Nursing Outlook*, Nov. 1974, pp. 708–11.)

Another consultant also suggested 5:1 as an appropriate ratio, but added that 10:2 would be preferable.

Length of time for the classes varied somewhat from 1½ hours of class and 3 hours of fieldwork during the first 2 semesters, to 2 hours of class and 6 to 8 hours of fieldwork per week in the last 2 semesters.

Similarly, the suggested class size spanned a rather wide range, depending on the intensity of the course; however, the experts seemed to agree generally that 5 should be minimum, 20 maximum, and between 6 and 10, "ideal."

Fieldwork Component

The question in fieldwork asked what type of community the student might gain experience in, who would supervise the students, and the most appropriate agency affiliation. Most responses in terms of type of community were quite specific, but several persons pointed out the need to mesh the experience with the student's career goals. Suggested communities were: a small neighborhood; two communities (one "complex, high risk" community and one "average" community); a school (for the student interested in school nursing); and, a senior citizen's center (for the student interested in geriatrics).

There were some mixed responses regarding agency affiliation: one consultant felt the student should not be assigned to a specific agency, but should maintain close contact with agencies in her neighborhood; another brought out the need for the student to establish a "base of support" in the community. In utilizing an agency as a base of support, this consultant suggested the criterion for the selection of the agency should be an established "positive relationship with the community."

According to one expert, "because the fieldwork is less structured than other learning experiences, faculty supervision is needed to validate the appropriateness of the data students collect." Others contend that the amount of supervision would depend upon:

- The individual needs of the student;
- The type and complexity of the community;
- The objectives identified for the learning experience;
- The type of community involvement planned; and,
- The ease with which the instructor can allow the student to be self-directed.

This last point is addressed by one consultant:

> I believe that community nursing is one area in which a student can have the opportunity to learn that there is no set of procedures, no definite black and white answers to problems, but that the problems are discovered and worked through with the community in a way that is consistent with their attitudes, values, and customs. I believe an instructor should stay in the background, guiding, facilitating, acting as a resource person, and above all providing support and encouragement. I think she should avoid giving direct answers, no matter how the students badger her, on what to do next or what approach to use, but rather should teach students how to generate and explore various possibilities. As a facilitator she should provide suggestions on how to search the literature, resource persons to tap, community agencies that might be of help, and she should occasionally drop a critical point or question to stimulate thinking. She should avoid becoming a 'come to me and I'll tell you what to do next' type of instructor.

Interdisciplinary Aspects

Responses to the question on interdisciplinary aspects are summarized in one consultant's remarks:

> It would be ideal if interdisciplinary teams of students could work in the community. At the very least, agencies and professionals other than nurses must be contacted by the students. I can think of no community health problem that is not fairly broad when one looks into the complex of variables that have gone into creating it. A broad approach to its solution will be more effective and should be learned while a student.

Expectations of Graduates

All agreed that expectations of graduates would depend upon the depth and comprehensiveness of the program, pointing out that, generally speaking, the baccalaureate graduate would not be expected to have the skills of a CNP. What several persons "hoped" was that the graduate would have a "beginning understanding of community development," and a "broader point of view."

Short- and Long-Range Possibilities for Implementation

Consultants involved in education agreed that implementation of CNP concepts into baccalaureate nursing education is a long-range possibility. Two persons mentioned the current "rage" of physical assessment and HEW-sponsored programs which focus on practitioner skills of a technical nature as the types of programs currently being emphasized. Faculty readiness and receptivity to CNP concepts, according to one consultant, "will take some time to develop." One educator summarized the possibilities:

> The potential I envision for the community nurse practitioner in nursing education would be to: (1) work collaboratively with social science, nursing, and medical faculty and students in the development of field studies, courses, and independent study, beginning early and following through several years into professional curriculums; (2) strengthen those faculty of the School of Nursing by including the community development component in the curriculums; (3) create liaisons in research/education/practice with colleagues in preventive medicine, primary care and family medicine; (4) become an integral part of a health service research center; (5) generate new and creative ways of working with defined community groups over time and/or in special summer projects; and (6) develop consortiums or contracts with other schools and communities on special projects, e.g., Appalachia/urban program/defined groups such as children or elderly.

Programs Preparing CNPs

The question asked was, "Are you aware of any educational program which prepares nurses to function in the way described?" The following programs were mentioned:

- The University of Illinois School of Nursing in conjunction with the School of Public Health;
- Indiana University School of Nursing Graduate Program in Community Health Nursing is "in the process of implementing selected components . . . that of community assessment, program planning and evaluation."
- "Several local [Houston, Texas area] universities include components of the CNP program in their basic nursing education."
- "The Columbia University community mental health nurse project of the 1950's and early 1960's under Dr. Ruth Gilbert had similar goals and methodology to that of the School of Public Health at Houston."
- "At the University of Michigan School of Public Health, Dr. Ruth Cummings developed a program for mental health nurses comparable to this program."
- Some components are included in basic nursing education programs at the University of Texas, St. Thomas University and Texas Woman's University (all in Houston). The consultant

> comments: "It is interesting to note that most of [the faculty involved in these programs] have done graduate studies in schools of public health."

One consultant, an educator in a basic nursing program, described in some detail her attempts at incorporating a "community focus" into a baccalaureate program. Her description, which brings out the pitfalls as well as the successes, is included in its entirety below:

> The only program that I am aware of similar to the one you describe is the one in which I taught at the University of Texas. The first aspect of this was the series of two electives in community nursing which I developed and taught.[1] The second aspect was the incorporation of concepts and processes, similar to those you describe, into our basic integrated nursing curriculum. The focus of the last semester as stated in the objectives of the 12-credit hour course, 'Nursing in Health Care Systems,' is to implement nursing process with societal groups and with complex health problems as seen in groups. Social disorganization was specified in the course objectives as one major pathology to be dealt with. To meet the objectives we divided students into groups of 8 to 10 and assigned each group a census tract within which they were to identify a community with which they could become involved for the semester. The process utilized was quite similar to those described in the projects you sent, except that the process was carried out on a very simple level and it did begin with a community assessment instead of with involvement. The course consisted of 2 hours per week of general community health concepts and content presented in lecture form to the entire group of approximately 80 students, 2 hours of seminar in which material presented in lectures was further explored by the students in small groups, and 2 hours of conference for discussion of laboratory experience. Laboratory time was about 16 hours per week.
>
> Several groups were quite successful on this simple, short-term level. Projects such as sickle cell screening clinics and an environmental health hazards reduction project were quite successful. One group did health hazard appraisals with followup counseling. Another group that worked in a census tract that had a large number of retired persons tried to inform them of community resources available to them. One group in a primarily middle class professional area could not interest the population in anything and wrapped up their project early. Even though all groups except one achieved at least some level of success, the students, faculty and administration were quite negative about the experience. Most students perceived it as a waste of time and evaluated it negatively, stating that they needed the semester to get more experience in the hospital, particularly in intensive care, emergency and other specialized areas in which they felt a lack. There was a high level of concern about failing state boards and needing more disease content.
>
> Only two of the nine faculty involved were prepared in community nursing. We were constantly overwhelmed by requests to come to seminars and tell the students precisely what to do next. We were surprised to discover that faculty who were very creative at using a variety of approaches to the difficult hospitalized patient could not transfer this to the community, and when community

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[1] See article, "Applying Nursing Process in the Community," *Nursing Outlook*, Nov. 1974, pp. 708–11.

members did not directly pick up on their plans were immediately ready to give up.

From this experience we concluded the following:

(1) A semester is not really long enough for meaningful involvement in a community.
(2) Faculty prepared in community nursing are needed—although nursing process is a general process, it is not easy to transfer from the individual to the large-group level.
(3) We had attempted too much too soon with students and faculty who were not convinced that this was nursing at all in spite of the fact that the system-wide objectives clearly seemed to indicate such a role along with its related content and processes.

Following this a revision was made. It was planned that the experience would begin in the student's first semester, at which time she would become familiar with a neighborhood and begin to assess it. In her second semester she would work with one selected family from that neighborhood and do a health resource assessment. In her third semester she would become involved with at least one agency or group in the neighborhood. She would at this time also analyze the data she had collected, identify problems, and with the community make plans which would be implemented and evaluated in her final semester. Although this revision was accepted by faculty vote it was never instituted due to various pressures that were being put on the school to return primarily to hospital nursing.

Continuing Education for Nurses

Questions asked about the desirability of implementing components of the CNP program into continuing education for nurses paralleled those asked about basic education. Many of the comments and suggestions, as well, were similar to those referring to basic education. For the most part consultants felt it appropriate and desirable to include the major concepts in continuing education, but did not feel this should take the place of a full graduate program for preparing the CNP.

Continuing education programs were variously described as aimed at helping professionals to update and broaden their knowledge and skills and at enhancing professional growth. As one consultant pointed out, "[a] high degree of interest [in continuing education] is illustrated by the rapidly growing trend for more and more nurses to choose this avenue for increasing their knowledge, skill, and ultimately their practice in an area of special interest." And, it might be added, the growing trend of State professional organizations and licensing boards is to require a certain amount of continuing education for relicensure.

Any continuing education program should be aimed at a specific audience. As one consultant suggested, "There appear to be three viable groups to which continuing education could be directed . . .

the master's-prepared health professionals who wish to teach and/or practice the role . . . the graduate CNP's . . . employers and potential employers of CNPs." Two employers of CNPs who are Consultants for this report expand this list to any nurse who is interested. Whichever group the program is aimed at, all consultants appeared to agree that the classes should be geared to actual problem-solving in role implementation and that a fieldwork component should be done in the agency of employment.

That a "one-shot" or short-term workshop is not adequate time for continuing education programs attempting to present the CNP concepts, was also a point of agreement among the consultants. The following methods of teaching and lengths of time for programs were suggested:

1. A few introductory lectures, but mostly seminars with assignments to work out in the employment situation; 2-hour seminar weekly for 12–15 weeks;
2. Programmed instruction, independent study, faculty site visits, television seminars, telephone conferences; begin with 2-week concentrated workshop, continue with monthly weekend sessions for 4 months and then quarterly for a year (a major point in this suggestion was the need for time to elapse between sessions in order to test "solutions" which may have been discussed); and
3. One or 2-day sessions for employers and potential employers. These would be held at 4- to 6-month intervals.

In summary, one consultant warned (and others seemed to agree) that the "classroom model" did not seem desirable to get at the CNP concepts: ". . . it would seem more desirable to devise a program in which participants would be introduced to theory, exposed to the actual practice of CNP-like persons in a field setting, and then facilitated to coming to grips with how they might utilize the insights/approaches in their own work setting."

As concluding remarks, one consultant's concerns about continuing education are included here for the thought-provoking issues they raise:

> Too often, nursing has invested its resources in short-term limited goals to address complicated long-term problems. If continuing education is used as a part of a larger design which permits nurses to capitalize on their learning investment and more toward well-defined education and practice goals, then I could support diverting a school's resources and distribution. However, the serious problems of nursing resources today are not the numbers of nurses but the types and kinds of nurses needed, and their distribution and utilization. We are sorely in need of well-qualified, committed careerists in every specialty field.

Implications for Preparation of Other Health Professionals

Consultants were asked: What are the implications of the preparation of community nurse practitioners for the preparation of physicians, statisticians, health educators, health planners, and other professionals for public health practice?

There seemed to be two distinct camps in terms of approaches to the question in this section: (1) those who addressed the need to "educate" other professionals about the CNP role; and (2) those who discussed the need for CNP concepts to become part of the armamentarium of other health professionals.

As one consultant related:

> If the CNP role is to become accepted in the growing galaxy of health professions, some physicians, statisticians, health educators, health planners and public health nurses and administrators will have to be acquainted with the role and recognize a place for it. Beyond that, health professionals who operate in agencies that are in contact with communities will have to understand that the field practice of the CNP is likely to produce pressures on them and even demands that they adjust their mode of role performance. The implication is that some training is necessary to prepare other health professionals who are likely to relate to and feel the effects of the CNP's work. It is not that they have to be trained in any radically new way, but educated to understand the function of the CNP. With some understanding of the CNP concept and function, the educated and experienced public health professional can see the specific implications on their own art and practice when in contact with CNPs and communities.
>
> In more general terms, all health personnel ought to be exposed to the value and philosophical questions that are intimately linked with professional practice in the public sphere in a democratic society.

Another consultant's remarks included the following:

> Community health, prevention, health promotion and self-health are concepts that can no longer be ignored by any health profession. Illness and wellness have their origins in the home and the community, and neither can any longer be properly dealt with in isolation. In addition, the development of attitudes necessary for working collaboratively with clients is most important for all.

Comments from another consultant about each of the health professionals listed in the question included the following:

1. Physicians—". . . [should] be urged to seek exposure to these concepts and encouraged to learn more about the community in which they practice."
2. Health educators—". . . come closest to seeing the community in the same light as the CNP."
3. Health planners—"Most . . . have had much theory and ivory tower 'know how' but very little community health experience, and they lack awareness of community realism."

4. Statisticians—"could bring more meaning to their findings and data if they had a better understanding of the community from which they receive such data."

One consultant expressed agreement that other professionals, just like other nurses, should be exposed to the philosophy of the CNP, but questioned whether or not they need to develop as sophisticated a knowledge base. She continued:

> I believe the outcomes would be more successful if an interdisciplinary approach to implementing the process were developed. . . . Nurses may be uniquely equipped to deal with the area of personal health services and the social-cultural aspects as they relate to coping processes; other professionals may be better equipped to deal with other phenomena such as the physical environment.
>
> Some of the other professionals . . . may be more skilled than CNPs in aspects of assessment (health planners and statisticians); however, their approach to getting data and the use they make of them may be considerably different. I believe such professionals could benefit from the reality orientation of a person operating as a CNP. Likewise, the effectiveness of a CNP-type person could be enhanced by close collaboration with those in other disciplines.

Finally, in relation to this question, one consultant reiterated his agreement with the orientation towards problem definition without preconceived limits on categories of appropriate intervention. He pointed out:

> An open-ended problem-solving orientation should constitute the basic professional perspective in the education of several categories of public health professionals. This applies to all those who will be candidates for roles in which this orientation can be effectively applied and followed up by appropriate actions: health officers, public health physicians, health educators, managerial staff in health departments, and health planners (if there are such people. I don't mean the growing cadre of health *care* planners, who are committed to one category of intervention.) I do not see this orientation as particularly useful to those who have chosen narrower technical fields such as statistics.
>
> Community development skills, which are also largely confined to elective courses, should also be part of the basic armamentarium of these professionals, and should be stressed for health educators particularly.

Another consultant brought out perhaps the most fundamental issue undergirding the CNP role:

> The whole health field has to decide whether there should be a place for partnership in policy determination and practice between citizens and professionals in the American democratic society. It seems to me that CNP role puts before the health professions an experiment to put in the field a special kind of colleague whose job is to develop and support the effort to use democratic processes in approaching community health. It certainly is not the only thing happening in this direction, but the CNP experiment is worthy of considerable observation by the allied health professions. It may go a long way in demonstrating, one way or another, whether democracy and public health can be compatible. That question has fundamental implications for all those dedicated to careers in health, and the eventual answer to it will have implications for the education of all health professionals.

Overall Reactions

Overall reactions of the consultants were mixed. There was agreement with the goals of individual and community self-help in attaining a higher level of health; the approach outlined was a positive step to work toward these goals; and the CNP was an innovative role for community health nurses. Areas that were singled out for positive reactions included the involvement of various disciplines to provide the students with a broader, more relevant perspective regarding community health concepts; the focus on a general process that can be used to attack health problems in a total community context; and the potential for the CNP to contribute to the increasing body of knowledge regarding community aspects of health care. One consultant summed up the favorable reactions: "I believe that your program prepares nurses to effectively stimulate, facilitate and cooperate with changes directed toward improved health."

Several of the consultants brought out negative aspects they encountered and suggested areas for further study and attention. The term nurse practitioner, in particular, seemed inappropriate to one consultant who pointed out that, "a more generic developmental term would be acceptable," and added, "The proliferation of names and categories [of nurses] is difficult to address." Content relevant to evaluation was found lacking in the seminar descriptions by one expert, and another encountered some conceptual difficulty articulating the combination of community development with clinical nursing.

Critical questions, some of which have been directly addressed by the CNP staff, were raised by a number of the consultants. Some of the questions were:

What should be the qualifications of students admitted to the program?
What type and kind of faculty is required?
What are the career goals of the students?
Is it unrealistic to expect completion of the curriculum in three semesters?
What are the students' problems in setting measurable goals for the community?
What is the career tract for the CNP beyond the master's degree?
Should the major methodology (participant-observer) require a broader base in social anthropology?
Should efforts to expand the methodologies include experimental and epidemiological designs, increasing sophistication in meas-

urement of outcomes, quantification of data, and analytical methods of interpretation?

Is there a need for faculty to act as role models for students to learn the process?

Where in the curriculum will policy development and policy analysis be addressed as an outcome of the community's development?

Additionally, one consultant stated, "I hope that the thrust of the program can be continued and that in the future additional attention can be given to various approaches to defining aggregates, role development in different health-care structures, and the increased use of epidemiological data and methods."

The CNP staff feels well advised by these consultants who so freely shared their thoughts and impressions. Most of the questions raised are addressed in various sections of this report. Others will require further deliberation and study. Nonetheless, they have stimulated fresh insights and some rethinking of "old" issues. That their contributions will have an impact on future programs which attempt to implement the CNP role cannot be overstated; they provide not only a critical appraisal of one program, but guidance and direction for programs to come.

In addressing the future of the CNP program, one consultant said that, "Through such programs it is possible to develop more realistic approaches to community health and . . . as professionals . . . improve the delivery of health care. As nurses we have a golden opportunity to be creative . . . in the best interest of mankind. The CNP concept is a step toward this goal."

Another seems to speak for all of us in his concluding remarks:

> There is no perfect world or place to prepare the perfect professional, but the imperfect CNP project made a good and profitable start. Whether there will be efforts to carry on the experiment will have a lot to do with making the most of the investment to date.
>
> As for me, I think the health field desperately needs, and communities are ready to accept, professionals on the order of CNPs. I can only hope that this and other experiments will be supported in health education. If we are not quite ready to count democracy out as a factor in improving public health, there should be room to keep working on the CNP concept and other kinds of professional roles.

Appendix A

COURSE DESCRIPTIONS FOR COMMUNITY NURSE PRACTITIONER SEMINARS

COMMUNITY NURSE PRACTITIONER

SEMINAR I

Special Topics in Community Development

Student's Objective: Gain entry to one specific community (geographic or otherwise) and, as a result of personal *interaction* with its members, demonstrate in written form a perception of the community's:

(1) Dynamics (emphasis on internal workings)
(2) Observable characteristics
(3) Relationships (emphasis on external)
(4) Needs (expressed and inferred)

Method Used: In behavioral science terms, both observation and participant-observation methods will be utilized. However, in plain ordinary language, the best tools a student can have for this quarter are a sense of respect for his (her) fellow human beings as their lives touch in the community situation; a questioning, curious mind increasingly able to follow new insights and bits of information; and the ability to listen, to touch, to taste, to smell, to see life as it is lived in the community.

Student's Goal: Gain a basic understanding of a specific community's life, with its strengths and weaknesses, its needs and wants—viewed, as much as possible, through the community's eyes.

Theory:	Community Development (CD) theory and principles will provide the basis for the student's activity in the community, but because CD by definition is eclectic, principles and methods from other disciplines will be discussed. In addition, because CD is by no stretch of the imagination a panacea or "cure all" for a community's problems, other models of community work, such as social action and social planning, will be discussed.
Seminar's General Aim:	To provide each student with principles and techniques sufficient for him (her) to hear what a given community is saying about its needs and priorities. It will be the objective of the second quarter to deepen the student's personal involvement in the community. At the same time, the information already gained will serve as a road sign leading to an analysis of published data regarding identified or inferred problems. It is not only possible but highly probable that conflicting analyses will result.
Requirements:	(1) Written paper reflecting the attainment of the student's objective. Where indicated, supporting theory and principles should be included. Paper is due on last day of classes. (2) Oral presentation of one aspect of the selected community's life, emphasizing the dynamics of the student's involvement in acquiring the information. Presentation is due at a mutually agreed upon time during the quarter. (3) Written list of community needs, problems, etc. for use during second quarter's assessment of the community. List is due on last day of evaluations. (4) Begin Community-Oriented Health Record.
Assumptions:	Health will be understood in its broadest sense.

PROBLEM ANALYSIS AND PLANNING INTERVENTION STRATEGIES IN THE COMMUNITY

Winter 1975-76

Overview

This course will focus on analyzing health-related problems in the community and on planning appropriate intervention strategies for their amelioration. Application of intervention strategies will be ongoing, as will the involvement in the community that was begun during the first quarter.

Certain key concepts pertinent to community work will be discussed by students in collaboration with faculty resource persons. These include: leadership, power, conflict, and organizational development.

Objectives

1. To analyze one health-related problem that has been identified in the community by:
    a. defining as precisely as possible the nature and extent of the problem; and
    b. describing and documenting the various factors that contribute to the existence of the problem.
2. To develop an approach to the amelioration of the problem through:
    a. determining possible intervention points;
    b. establishing goals and objectives; and
    c. determining appropriate actions to meet objectives.
3. To design methods of evaluation for the intervention.
4. To systematically record all activities in the community that are related to the plan.

Method

The class will be conducted as a seminar in order to foster free expression of all participants. Students as well as faculty will be expected to lead discussions during this quarter.

Faculty

Members of the faculty are Bets Anderson, Janet Gottschalk, Deanna Grimes, and Clarence Skrovan.

Expectations

1. Continued involvement in the community to discuss problem analysis and plan with persons and groups within the community. The final plan should reflect input from the community.
2. Systematic documentation of community activities.
3. Analysis of one problem (will be discussed Week 3).
4. An oral discussion of the plan for community interventions relating to the problem analyzed. Part of the discussion will include presentation of one key concept: its relevance in the particular community, as well as current thought on the topic (relevant research, etc.).
5. Written plan for community interventions related to the problem analyzed (due during Week 9).

Topical Outline

Week	*Dates*	*Topic*	*Resource person*
1	1/5–9	Problem Identification Feedback of Quarter	D. Grimes
2	1/12–16	Models for Analysis	B. Anderson
3	1/19–23	Problem Analysis Feedback	All staff
4	1/26–30	Goals, Objectives, Responses and Evaluation	C. Skrovan
5	2/2–6	Real-World Constraints on Selecting Interventions	J. Gottschalk
6	2/9–13	Intervention: One CNP's View	R. Fendrick
7	2/16–20	Plan Presentation: Focus on Leadership	Student (BA)
8	2/23–27	Plan Presentation: Focus on Power	Student (JG)
9	3/1–5	Plan Presentation: Focus on Conflict	Student (JG)
10	3/8–12	Plan Presentation: Focus on Organizational Development	Student (DG)

Suggested Readings (Books)

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IMPLEMENTING THE CNP ROLE

Spring 1976

Objectives

1. Increased confidence and competence in working with community groups.
2. Provision for continuity of CNP's efforts in the community.
3. Understanding of the CNP role and its place in a specific agency.

Expectations

1. Continued community work with emphasis on:
   A. One or more of the following—
      (1) secondary assessment of the community,
      (2) further problem identification and analysis,
      (3) further development of intervention strategies (i.e., plan), and
      (4) implementation of a plan.
   B. Working with community leaders and agency personnel to provide for continuity of CNP's efforts after her departure from the community.
2. Development of a job description and record for the CNP role within a specific type of agency. The job description and record will include specific elements developed in class. Typed job description and record due May 20. Oral presentation of job description and record will be held May 25 and May 27.)

Suggested Sample Elements of Job Description and Recording Plan

1. Job description
   a. description of CNP role
   b. rationale for use of CNP within that specific agency
   c. strategies and resources to be utilized (spell out activities regarding individuals, groups, and agency personnel)
   d. statement of evaluation of the impact of CNP activities.

2. Record basically or outline with some examples
    - a. specify major categories of data to be gathered for community *assessment*
    - b. develop a framework for presentation of community data, so that agency and community can understand
    - c. problem list—major problems, priorities
    - d. intervention strategies
    - e. progress notes regarding activities undertaken.

COMMUNITY NURSE PRACTITIONER WORKSHOP

September 3-13, 1974

Overview

Planned for nurses who will be entering the Community Nurse Practitioner Project in October, the 2-week workshop is designed to introduce the student to the basic concepts inherent in the CNP role and to give the student an opportunity to explore various community settings for fieldwork experiences.

Objectives

1. To formulate a definition of the CNP role that demonstrates an understanding of the forces which led to its development, its relationship to other roles in the community, and to an understanding of the concepts inherent in the role.
2. To examine the beginning concepts of "community" and to become familiar with at least one community in the Houston area.
3. To identify a community in which to practice the CNP role during the school year.
4. To explore adapting the problem-oriented record for use in community work.

Method

The workshop will be conducted primarily by the seminar method to enhance active involvement of all participants. Audiovisual materials and some lecture-discussion periods will also be used. Fieldwork experience is planned to enable the student to observe and explore selected communities in the Houston area.

Faculty

In addition to CNP staff, resource persons have been selected from various disciplines such as medicine, nursing, sociology, anthropology, and health education to assist with instruction and serve as consultants in their respective specialties.

Resource Materials

Pertinent resource materials (reprints, booklets, and mimeographed presentations) will be available for students' use in preparing for the workshop sessions. Books and article reprints relating to the CNP role are available in the CNP office and may be checked out through the secretary. Students may also use the resources of the UTSPH library and the library of the Texas Medical Center (Jesse Jones Building).

Requirements

1. Annotated bibliography cards on all readings relating to the CNP role.
2. Written description of the CNP role—due September 20 (end of Orientation Week).

Evaluation

A group oral evaluation will be held the last day of the workshop to identify students' needs for the coming year.

A written evaluation of the total workshop, using an evaluation guide, will be handed in during Orientation Week.

Faculty and Resource Persons

Elizabeth T. Anderson, R.N., M.S., Codirector, Community Nurse Practitioner Project

John Bruhn, Ph.D, Associate Dean for Community Affairs, University of Texas Medical Branch, Galveston

Rick Fendrick, R.N., M.P.H., Community Development Specialist, West End Health Center, Houston

Maxine Geeslin, R.N., M.P.H., Director, Division of Public Health Nursing, Texas State Department of Health

Janet Gottschalk, R.N., M.S., Associate Director, Community Nurse Practitioner Project

Ramona Johnson, R.N., M.S., Assistant Professor, Texas Woman's University, Houston

Kathy Jordan, R.N., M.P.H., Assistant Professor, University of Texas School of Nursing at Houston

Jeane Knight, R.N., M.S., Associate Professor, University of Texas School of Nursing at Galveston

Hilda Kolva, R.N., Pediatric Nurse Practitioner Program, University of Texas School of Nursing at Galveston

Mary Lemon, R.N., M.P.H, Community Nurse Practitioner, Yorkline Community Center, Houston
Jo Mapel, R.N., M.P.H., Community Nurse Practitioner
Al Randall, M.D., Director, City of Houston Health Department
Gene Schulle, M.S., Director, Health Education, City of Houston Health Department
Clarence Skrovan, M.D., M.P.H., Codirector, Community Nurse Practitioner Project
Gerda Smith, Ph.D., Division of Community and Social Psychiatry, University of Texas Medical Branch, Galveston
Edith Wright, R.N., M.S., Director, Family Nurse Clinician Program, Texas Woman's University, Houston

Appendix B

EVALUATION QUESTIONNAIRE: GRADUATE'S EVALUATION

Community Nurse Practitioner Project

EVALUATION, STUDENTS' VIEWPOINT

1. How aware were you of the objectives (attached) of the CNP program during your time as a student in the program? Please indicate the extent of your awareness by placing a check mark in the appropriate column on Sheet A. Objectives Awareness.
2. How relevant (appropriate) were each of these objectives to your learning needs as a student in the program? Please indicate the extent of relevance by placing a check mark in the appropriate column on Sheet B, Objectives Relevance.
3. Please indicate the usefulness of the classroom (theoretical) experiences in relation to developing skills, knowledge, and attitudes basic to becoming a CNP by placing a check mark in the appropriate column on Sheet C, Overall Course Evaluation.
4. Please indicate by placing a check mark in the appropriate column the extent to which your field experience in your selected community was:

	Very	*Somewhat*	*Not Very*	*Not*
a. helpful in attaining your educational objectives	------	--------	--------	-----
b. related to the overall objectives of the CNP program	------	--------	--------	-----
c. integrated with the major concepts presented in seminars	------	--------	--------	-----

5. What criteria would you consider most important in choosing a community for a student experience?
6. What was the major benefit *you* derived from your field experience in your selected community?

7. What was the major benefit *the community* obtained from your involvement as a student CNP?
8. Who in the community would we contact for information about what's happening in the community today?
9. In what way(s) should the CNP program be modified in order to improve it? In terms of:

time—

courses—

fieldwork—

methods of teaching—

other—

Objectives

1. Analyze the role of the CNP in relation to:
    - (a) Community health nursing theory and principles; and
    - (b) Community development/organization theory and principles.
2. Gain entry to one specific community (geographic or otherwise) and, as a result of personal *interaction* with its members, demonstrate in written form a beginning perception of the community's:
    - (a) Dynamics (emphasis on internal workings);
    - (b) Observable characteristics;
    - (c) Relationships (emphasis on external); and
    - (d) Needs—expressed and inferred.
3. Synthesize available data to draw inferences about the health status of the caresphere and to develop a list of the community's problems.
4. Analyze the role of the CNP in relation to the caresphere.
5. Analyze one "real" or potential health-related problem that has been identified in the community by:
    - (a) Defining as precisely as possible the nature and extent of the problem, as well as its priority to the community; and
    - (b) Describing and documenting the various factors that contribute to the existence of the problem.
6. Develop an aproach to amelioration of the problem through:
    - (a) Determining possible intervention points;
    - (b) Establishing goals and objectives; and
    - (c) Determining appropriate actions to meet objectives.

7. Continue involvement in the community to discuss problems analysis and plan intervention with a person or group within the community.
8. Design a method of evaluation for the intervention (s).
9. Record activities in the community using a community-oriented system.
10. Begin implementing plans for alleviating health-related problems in the community.
11. Provide for continuity of intervention activities in the community.
12. Evaluate intervention (s) and role of CNP in the community.

Additional Questions Asked Over Telephone

1. Was your student experience with the Community Nurse Practitioner Program positive or negative?
2. What contributed to its being either positive or negative?
3. What is your present job?
4. Do you utilize aspects of the Community Nurse Practitioner Program in your work situation? Please elaborate.
5. Do you refer to yourself as a community nurse practitioner?
6. How do you define a community nurse practitioner?

SHEET A, OBJECTIVES AWARENESS*
(Question 1)

OBJECTIVE	Very Aware	Somewhat Aware	Unaware	REMARKS
1 a b				
2 a b c d				
3				
4				
5 a b				
6 a b c				
7				
8				
9				
10				
11				
12				

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* See Objectives Shee

SHEET B, OBJECTIVES RELEVANCE*
(Question 2)

OBJECTIVE	Most Relevant	Somewhat Relevant	Irrelevant	REMARKS
1 a b				
2 a b c d				
3				
4				
5 a b				
6 a b c				
7				
8				
9				
10				
11				
12				

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*See Objectives Sheet

OVERALL COURSE EVALUATION SHEET C

COURSES Usefulness →	very	some-what	not	N/A*	REMARKS
First Quarter CNP Seminar ( )					
Second Quarter CNP Seminar ( )					
Third Quarter CNP Seminar ( )					
Bases of Community Health (CORE)					
Introduction to Epidemiology					
Epidemiology Second Course					
Introduction to Biometry					
Biometry Second Course					
Introduction to Health Services					
Program and Policy Planning I					
Program and Policy Planning II					
Management Methods					
Public Administration and Public Health					
History of Medicine					
Growth and Development					
Health Dept. Management					
Mental Health (specify)					
Demography					
Health Aspects of Urban Design					
Urban Settlement Patterns					
Maintenance & Promotion of Health					
Politics of Health					
Maternal and Child Care					
Aspects of Aging					
Other (specify):					

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*Not applicable

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